Jamestown REGIONAL MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

Completed by Jeffery Plemel

I, _____ _____ _____

(Name of Patient) (Date of Birth) (Phone Number)

hereby authorize you to release the following information from my medical records:

FROM:		**TO:**	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Phone #		Phone #	
Fax #:		Fax #:	
Purpose of Release:			
From (Date):		To (Date):	

Check all the apply:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Other (Please Specify):
- ☐ Pathology Report
- ☐ Laboratory Results
- ☐ X-Ray Reports
- ☐ EKG/EEG Reports
- ☐ Emergency Room Reports
- ☐ Prenatal Records
- ☐ Outpatient Clinic Notes
- ☐ Consultation Reports
- ☐ Therapy Notes

SPECIFIC AUTHORIZATON FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State law relative to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) or human immunodeficiency virus(HIV). It may also include information about mental health services or treatment for alcohol and/or drug abuse.

I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO:

Circle "Yes" *or* "No" next to all spaces provided.

YES / NO Substance abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

YES / NO Mental health information from all health care providers and facility and any other person or entity in possession of records concerning me.

YES / NO HIV or AIDS related information, diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company when the law provides my Insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, **this authorization will expire six months from the date I signed it**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the privacy officer.

_____ _____

Signature of Patient/Legal Representative | Relationship to Patient if signed by Legal Representative

_____ _____

Date | Witness

Records were:
- ☐ Sent with Patient
- ☐ Mailed
- ☐ Faxed

HIS please make copies and:
- ☐ Sent with Patient
- ☐ Mailed
- ☐ Faxed