



**REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS**

**Patient** \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**Date of Birth** \_\_\_\_\_  
Phone \_\_\_\_\_

I hereby authorize and direct \_\_\_\_\_ to furnish  
to \_\_\_\_\_ phone \_\_\_\_\_  
at \_\_\_\_\_ fax \_\_\_\_\_  
E-mail \_\_\_\_\_

the following information from my medical record (please check type of record below)

| Type of Record Requested                    | Date | Type of Record Requested                     | Date |
|---|------|--|------|
| <input type="checkbox"/> Hospital Inpatient |      | <input type="checkbox"/> Outpatient          |      |
| <input type="checkbox"/> Emergency Services |      | <input type="checkbox"/> Skilled Nursing/ICF |      |

I authorize the following information to be released (please check)

|  |   |
|--|---|
| <input type="checkbox"/> History & Physical Exam   | <input type="checkbox"/> Radiology Reports                        |
| <input type="checkbox"/> Emergency Room Reports  | <input type="checkbox"/> Consultation Report                      |
| <input type="checkbox"/> Nursing Notes   | <input type="checkbox"/> Progress Notes                           |
| <input type="checkbox"/> Operative Report  | <input type="checkbox"/> EKG/EEG Interpretations                  |
| <input type="checkbox"/> Immunizations   | <input type="checkbox"/> Discharge Summary or Final Diagnosis     |
| <input type="checkbox"/> Lab/Pathology Reports   | <input type="checkbox"/> Physical, Occupational or Speech Therapy |
| <input type="checkbox"/> Only the information deemed necessary as stated in the purpose for release. | <input type="checkbox"/> Other (please describe)                  |

**The Information being disclosed may be used only for the following purposes** (please specify)

- Payment or Reimbursement     Utilization Review     Continuation of Care  
 Other-specified here \_\_\_\_\_

**Information furnished in the form of (please circle one)    Copies    Mail    Fax    Secure E-Mail**

I understand that this authorization is effective for 90 days from the date it is signed or \_\_\_\_\_ days, which ever is longer. I understand that I may revoke this authorization at any time except to the extent that actions have already been taken in reliance upon it, by giving notice to the Health Information Department. I understand that I have the right to inspect the information disclosed upon proper notification and under appropriate conditions established by Burgess Health Center.

**Specific Authorization for Release of Information Protected by State or Federal Law**

I specifically authorize the release of this Information as indicated by my initials OR if N/A

| Type of Information to be Released                | Initials of Patient or Legal Representative | Date |
|---|---|------|
| Alcohol/Drug Abuse Diagnosis/Treatment            |   |      |
| Mental Health Diagnosis/Treatment                 |   |      |
| AIDS Related Diagnosis/Treatment/HIV Test Results |   |      |

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Address if Different than above

\_\_\_\_\_  
Date of Authorization

**This information has been disclosed to you from records whose confidentiality is protected by State laws. State law prohibits you from making further disclosure of the information without specific written consent of the person to whom the record pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.**