

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

**Patient's Full Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
 Former Name(s) \_\_\_\_\_ SS# \_\_\_\_\_

**I authorize CENTRAL PENINSULA HOSPITAL, INC. to release to:**

**Name** \_\_\_\_\_ **Phone#** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Fax#** \_\_\_\_\_

**Information to be released:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Emergency Reports    | <input type="checkbox"/> EKG Reports   |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Surgical Reports   | <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> X-Ray Films   |
| <input type="checkbox"/> Other (list)       |   | (refer to Img Dpt)                     |

**For the purpose of:**

- Further medical treatment
- Payment of claim
- Legal Request
- Personal
- Other (list)

**Date(s) of Service:** \_\_\_\_\_

**I acknowledge** that the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

**I understand** that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization, and that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In absence of a revocation, this specific authorization expires on \_\_\_\_\_ (if left blank, will expire 90 days from date of my signature). Maximum for authorization is 1 year from date of signature.

**I understand** that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

**I understand** authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

\_\_\_\_\_  
**Patient or representative signature**                      **Date**                      **Witness**

**FOR CPGH USE ONLY**

# PAGES \_\_\_\_\_ # FILMS \_\_\_\_\_ FEE \$ \_\_\_\_\_ PROCESSED BY \_\_\_\_\_ DATE \_\_\_\_\_

RECORDS WERE     MAILED     PICKED-UP     COURIER     FAXED to # \_\_\_\_\_

RECORDS TO BE PICKED UP ON \_\_\_\_\_ CONTACT PHONE # \_\_\_\_\_

**Receipt for Hospital Record Copies**     ID Checked

I hereby acknowledge receipt of the above noted medical records

_____ Signature                      Date	<b>RETRIEVAL AND COPY FEES</b> 1-5 pp                      \$10.00 ea addtl                      \$ .50 Xray Films                      \$10.50/sheet Photos                      \$ 2.50/pg STAT Fee                      \$20.00 Cert of Auth                      \$20.00
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**Patient Copy**    \_\_\_\_\_ **Given**    \_\_\_\_\_ **Declined**

**COMPLETED FORM TO BE FILED ON PATIENT'S RECORD**