BROOKS MEMORIAL HOSPITAL
Authorization for Release of Information

1. I hereby authorize **Brooks Memorial Hospital** to release the following information from the medical record of _____

   Date of Birth _____ Social Security # _____

2. Information to be released:

   Date of admission _____ Date of Discharge _____

   ____ Copy of complete hospital record(s)

   ____ Discharge summary

   ____ History and Physical Examination

   ____ Other: _____

3. The above information is released to: _____

   _____

   _____

   _____

   for the following purpose: _____

4. This Authorization expires 6 months from the date signed below and covers only treatment for dates specified above.

   _____ **I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.**
   Initials

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn, by written request from me, at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization. I understand federal and state laws permit a fee to be charged for copying a patient records.

_____	_____	_____
Date	Signature of Patient/ Parent/ Conservator/ Guardian	Relationship to Patient/ Authority to act for patient

_____	_____
ID Presented	Verified By

THIS AUTHORIZATION WILL NOT BE VALID UNLESS ENTIRELY FILLED OUT

Notice to the Recipient: The recipient of the enclosed information is not authorized to use this patient's Medical Records information for any purpose other than for that stated above or to disclose any information to any other person of facility without specific written authorization for the patient to do so.

ADDRESSOGRAPH
Med Rec #: Acc #: Admit Date: Attend Phy: Sex: Date of Birth: Age: Patient: Address: , Admitted By:

PF1186