POWER COUNTY HOSPITAL DISTRICT
Quality Care, Close to Home

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name _____ Date of Birth _____ Medical Rec # _____

Address _____ Phone # _____
Street City State Zip

This is to authorize that medical information regarding the above identified person be released **FROM:**

⬭ **Power County Hospital** ⬭ **Power County Physical Therapy**
⬭ **Power County Family Clinic** ⬭ **Aberdeen Family Clinic**

_____
OR Facility/Person receiving records

_____
Address City State Zip

_____
Phone # Fax # Email

Records to be released **TO:**

⬭ **Power County Hospital** ⬭ **Power County Physical Therapy**
⬭ **Power County Family Clinic** ⬭ **Aberdeen Family Clinic**

_____
Facility/Person receiving records

_____
Address City State Zip

_____
Phone # Fax # Email

COPIES OF RECORDS REQUESTED: (Check all that apply)

_____ History & Physical
_____ Discharge Summary
_____ Operative Report
_____ Pathology Report
_____ X-Ray, CT-scan Report
_____ Physician's Orders & Progress Notes
_____ Emergency Room Record DOS:_____
_____ Laboratory Work
_____ Clinic Records
_____ All records (state need for all)
_____ Alcohol or Drug Abuse Records (**Initial to be Valid)** ____

Please send my records in electronic or print form via: _____ E-mail _____ Fax _____ Disc _____ Mail _____ Pick-Up

This authorization is valid for **six months** from the date signed below.

This authorization may be revoked at any time in writing. For instructions on how to revoke this authorization, please refer to the *"PCHD Notice of Privacy practices"*. Treatment or payment may not be conditioned upon our receipt of authorization.

Releasing medical information as a result of this authorization may mean that your medical information could be re-released by the recipient and no longer be protected by Federal Privacy Rules.

Signature: _____ Date: _____

Signature of Other: _____ Relationship: _____
If signed by other than patient, state relationship and legal reason to do so (patient is incompetent, minor, etc.)

Witness: _____ Date: _____