



# 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 Family Clinic
- Power County Physical Therapy
- 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 Family Clinic
- Power County Physical Therapy
- 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: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_