

Authorization to Release Patient Information

Medical Record #: _____

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below or is revoked in writing. A copy of this signed form will be provided to the patient on request.

I hereby authorize [name of provider/address]: Floyd County Medical Center

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Email address
XXX-XX-

Date of Birth Last four of SS# Home telephone Work/Cell telephone

Address: _____
Street City ST ZIP

This information to be disclosed to:

(If another person/entity, include full address, fax number, or email.)

Covering the periods of healthcare Date(s) of Service: From: _____ To: _____

For the purpose of: _____ At the request of the patient or their representative
(Not required if the disclosure is requested by the patient.)

Method of Release: Mailed Paper Mailed encrypted CD/DVD Encrypted email Pick up paper Pick up encrypted CD/DVD Fax

The following information may be released: **Be specific on information requested:**

- Demographic History & Physical ER Report Consult OP Note Progress Notes Disch Summary
 Disch Instructions Transfer Sheet Laboratory Pathology Radiology Report Radiology Film EKG
 Echo Phys Ther Notes Speech Notes Occ Ther Notes Wound Care Notes Complete Record Insurance Form
 Itemized Bill UB Bill (inpt) 1500 Bill (outpt) Other (explain) _____

Visit #: _____

I understand that this will include information relating to (initial if applicable):
 Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) testing, results, diagnostics
 Drug and alcohol testing, results, diagnostics
 Mental/behavioral health assessment, treatment

I authorize transmission of my medical information by FAX machine.

I authorize transmission of my medical record by email. I understand that even when encrypted, emailed information could be read by a third party and FCMC cannot guarantee secure delivery.

Affirmation of Release

I give __ FCMC _____ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this authorization may include disclosure of information related to alcohol, drug abuse, mental health treatment, and HIV/AIDS results. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan health care clearing house covered by the federal privacy regulations, or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

Signature of Patient/Guardian/Legal Representative

Date Signed

Signature of Witness

Date Signed

Information sent?

Expiration Date: One year from date signed or by giving other specific written notice to the health care provider. This authorization can be revoked by written request.



Release # _____ Date: _____