Authorization for Release to Methodist Healthcare

I, _____, do hereby authorize _____
Patient's Name *Agency or Individual*
to release to _____Methodist Healthcare_____

the medical records prepared by personnel of the hospital, or by staff physicians or other health care providers during the referenced admission, relating to my treatment in said facility for the following purpose:
□Continuity of Care □ □Personal Health Record □ □Legal □ □Other:_____

The information released shall be limited to the following date(s) of treatment:

Include also the following specific type data (check all that apply)**:**

□Discharge Summary □ □ Radiology Reports □Labs □
□History & Physical □ □Outpatient Clinic Records □ □Abstract (Pertinent Reports from Visit)
□Operative Report □E.D. Provider Note□ □Entire Medical Record

□Other_____

Expiration Date:

- The expiration date or expiration event for this authorization is_____
- If no expiration date or period is known it will expire **six (6) months** after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the Health Information Management Department of the above-named facility. The request to revoke authorization must contain the signature of the patient or the patient's legal representative and must be notarized.
- Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if facility has not taken action in reliance thereon.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
- This authorization also includes any information related to diagnosis and/or treatment of any genetic condition psychiatric or mental illness and/or any state of infection with the HIV (AIDS) virus.
- This authorization covers materials considered "hospital records" reasonably capable of being reduced to printed form.

Methodist Le Bonheur Healthcare and its affiliates are hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law.

_____ _____
Signature of Patient or Authorized Individual Date

_____ _____
Relationship if signed by Other than Patient Patient's Social Security Number

_____ _____
Street Address Patient's Date of Birth

_____ _____
City State Zip Code Phone Number

To receive the above requested records electronically via a secure web link, please provide email address

_____

For Office Use: Photo ID Provided_____yes_____no. If no, the form of patient ID must be stated _____

Witness Date _____