



South Pointe Hospital

Authorization for the Release of Protected Health Information

I give permission for South Pointe Hospital to:

Release to Receive from

Name of person/Doctor/Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: () _____ Fax: () _____

Information to be released:

Emergency Record Operative Report Consult Report Lab EKG
 Discharge Summary Pathology Report Radiology Report History & Physical

Other: _____

Date(s) of treatment: _____

Purpose of disclosure: Continuity of care/follow up Personal use Legal
 Insurance Disability Other: _____

Patient Name: _____ SS#: _____ Date of Birth: _____

Telephone#: () _____ Current Address: _____

This authorization will expire in 60 days unless otherwise stated: _____

I hereby authorize South Pointe Hospital and it's employees the right to release any and all information contained in my medical records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results, diagnosis and/or treatment.

I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to redisclosure by the recipient.

Access to medical information is the right of every patient, duplication and distribution is a service. As a professional courtesy, no cost is assessed for information released directly to your helath care provider; all other releases are subject to costs for copying and distribution.

I understand that I am not required to sign this authorization and may refuse to sign it. I understand that I need not sign this form to ensure healthcare treatment.

Signed: _____ Date: _____

Patient, Guardian, Administrator, Executor or next of kin (circle one)

If person other than patient signing please include appropriate legal document(s).

Distribution: Original - chart Copy - patient Copy - Requestor