CODY CLINIC

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Release of Information

Patient Name: _____ Date of Birth: _____

I hereby authorize _____
(Organization name & address)

to release to _____ until further notice.
(Organization name & address)

[ ] Complete Records
[ ] Pathology
[ ] History & Physical Report
[ ] Emergency Room Report
[ ] Operative/Procedure Report
[ ] Lab Reports
[ ] Medication Record
[ ] Treatment Record
[ ] Progress Notes
[ ] Radiology Reports
[ ] Operative Reports
[ ] Other (please specify)
_____

The purpose/reason for this release of information is as follows:

_____

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
2. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I
3. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
4. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
5. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).
6. A copy of this form shall be counted true and valid as the original.

_____ _____
Signature of Patient or Representative Date

_____ _____
Relationship to Patient Signature of Witness