Authorization for Request of Protected Health Information

I, ___________________________________, do hereby consent and authorize Hugh Chatham Memorial Hospital to disclose to ___________________________________ information from the hospital's records relating to the patient's identity, diagnosis, prognosis, and treatment, including but not limited to the treatment of drug or alcohol related illness, psychiatric treatment, diagnosis or treatment of HIV related illness, sickle cell or hepatitis. I understand the extent or nature of the medical information to be disclosed includes (specify DOS and type reports): ____________________

____

I also understand that the purpose of this disclosure is to:______________________________________

____

Furthermore, I understand that this authorization is revocable by me, at any time, if I provide a written, signed notice except to the extent that action has been taken on this release. Otherwise, this consent will remain in force for 90 days.

Special limitations or instructions (if any): ____

____

______________________________ ___________ ____

Patient Signature Date Witness

____

Signature of parent/legal guardian or authorized representative

Date of Birth___________________

Identification __________________

MR#:_________________________

ROI # ________________________

Account# _____________________

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