Hugh Chatham Memorial Hospital

Authorization for Request of Protected Health Information

I, _____, do hereby consent and authorize Hugh Chatham Memorial Hospital and Affiliates, 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#:_____

ACCT#_____

ROI#: _____