Authorization for Release of Medical Records

1 I hereby authorize Cameron Health (Cameron) to release my Information to:

Name: _____

Address: _____

Fax #: _____ Phone #: _____

2. Patient's Full Name: _____

Patient's Address: _____

Patient's Telephone Number: _____ Date of Birth: _____

3. The purpose for which the following information is being requested: _____

☐Continuing Care ☐Personal Use ☐School ☐Legal

☐Other_____

4. I authorize the following information to be released from my medical records:

Date(s) of Service(s): _____

☐History and Physical ☐Progress notes ☐Consultation(s) ☐EKG(s) ☐Photographs, Video tape, Digital or other Images

☐Discharge Summary ☐Surgery Report(s) ☐Labs (Incl. HIV) ☐X-Ray Report(s) ☐ER Record ☐Imaging Report (s)

☐ Pathology Report ☐Doctors Orders ☐Medications ☐UB-92 or Itemized Bill

☐Other (Please Specify) _____

M.D Office Visit

☐Cameron Orthopedics ☐Cameron OBGYN ☐Cameron Pediatrics ☐Cameron Psychiatry ☐Cameron E.N.T

☐Cameron Family Medicine ☐Cameron Immunization Clinic ☐Urgent Care ☐Cameron Cardiology ☐Cameron Podiatry

☐Cameron General Surgery ☐Cameron Wound Clinic ☐Cameron Urology ☐Cameron Gastroenterology

☐Other (Please Specify) _____

Sensitive Information: ☐Psychiatric/Behavioral Diagnoses ☐Communicable diseases, including HIV status ☐Genetic Testing

5. I am requesting my medical records in the following format:

☐Paper ☐CD/DVD

☐Email Address_____ **(I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)**

☐Mail to Address Above ☐I will pick up in person ☐Fax

6. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon this authorization. This authorization will be valid for sixty (60) days from the date of request, unless otherwise specified by the following date, event or condition:_____

- I understand that no treatment, payment, enrollment, or eligibility for benefits may be conditioned on whether I sign this authorization.
- Cameron cannot prevent redisclosure of Cameron information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Cameron from all liability resulting from a redisclosure by the recipient.

Printed Name: _____

Patient Signature or Legal Representative: _____ **Date:** _____ **Time:** _____

Relationship to Patient: _____**Date:** _____ **Time:** _____

Interpreter, if Utilized: _____ **Date:**_____**Time:**_____

Witness:_____ **Date:**_____**Time:**_____

TO BE COMPLETED BY HOSPITAL STAFF:

ED/Radiology/Med-Surg Released □ **HIM to Release**□

Print Name of Person Releasing Information: _____**Date:** _____

☐**Photo ID/signature verified** **Medical Record Number:** _____

All entries must be dated and timed.

Place Patient Label or

Patient Name_____

DOB_____

MRN_____