AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I _____, do hereby request, direct, authorize and consent to the Halifax Regional Hospital disclosure of any and all medical information, including documents or other medical records to

_____

(Name, Address, Telephone #)

This request includes any and all hospital records regarding my treatment, hospitalization, and/or outpatient care for my condition including, but not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, or HIV (Human Immunodeficiency Virus or Aids). I fully understand that the specific type of information to be disclosed includes but is not limited to:

Dates of Service:_____

Discharge Summary	_____	History and Physical	_____
Physician's Progress Notes	_____	Physician's Orders	_____
X-Ray Report	_____	Lab Report	_____
OR Report	_____	Physical Therapy Notes	_____
ER Report	_____	Path Report	_____
EKG	_____	Consult	_____
Resp. Therapy (Specify)	_____	Entire Chart	_____
Psychotherapy Notes	_____	Other _____	

and that this disclosure is necessitated by _____.

You may revoke this authorization at any time. See the HRHS Notice of Privacy Practices for more information about revoking an authorization. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I hereby release the Halifax Regional Hospital from any and all claims or demands, causes of action of any nature and any type resulting from a disclosure of any medical records or other information in conformance with this authorization.

Dated this _____ date of _____, 20_____

_____ _____

Patient or Authorized Agent's Signature Witness

_____ _____

Relationship to Patient Witness

This authorization is valid for this request only unless otherwise specified. Expiration _____.

Health Information Dept. Phone # 434-517-3161 Fax # 434-517-3939

#ADM003#

Halifax Regional Hospital
Rev. 03/10 Pg. 1 of 1

Authorization to Release Patient Records

View Only _____
Copies requested _____

Medical Record No._____
D.O.B. _____
S.S.# _____
Acct.# _____
Completed _____