MURRAY COUNTY
MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patient Identification:	Name: Date of Birth: MR#: Address: Phone #: City/State/Zip: Maiden/Previous Names/Nicknames: Patient Social Security #:
Provider Who is releasing the information?	Provider/Facility Name: Address: City/State/Zip: Phone #: Fax #:
Disclose Information to Where is the information to be sent?	Provider/Facility Name/Other: Address: City/State/Zip: Phone #:
Information to be Released	☐ Clinic Progress Notes ☐ Hospital Progress Notes ☐ Immunization Records ☐ History & Physical ☐ Operative Report ☐ Psychiatric Evaluation ☐ Outpatient Information ☐ Laboratory Data ☐ EKG/Cardiology Reports ☐ Radiology Reports ☐ Radiology Films ☐ ER Records ☐ Discharge Summary ☐ Pathology Report ☐ Treatment for Drug/Alcohol ☐ Consultation ☐ All Records ☐ Other (Specify): _____
Service Dates	Time period from: _____ to _____ Concerning (Specific Diagnosis or Treatment, Auto Accident, etc.) _____
Purpose of Disclosure	☐ Continuing Medical Care ☐ Insurance Claim ☐ Consult/Second Opinion ☐ Other (Specify): _____ ☐ Personal ☐ Legal ☐ Out of Town Move
Expiration Date	This Authorization will expire one year from the date of signature or on:
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.
Authorization	I understand that the specific information to be released will only include the items have checked above. If All Records was checked, then all categories listed will be provided. I authorize release of this specific data. I understand that if the organization authorized to receive the information is not a health plan or a health care provider the released information may no longer be protected by Federal Privacy Regulations. I have read and understand this consent. I have signed this consent voluntarily and of my own free will.

Patient Signature/Representative: _____

Relationship to patient if not self: _____

Witness Signature: _____ Today's Date: _____

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507.836.6700
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The Murray County Medical Center is an Equal Opportunity Provider & Employer