METHODIST HOSPITAL
1305 North Elm Street
PO Box 48
Henderson, KY 42419
www.methodisthospital.net

Authorization for Disclosure of Health Information

1. I hereby authorize (releasing facility) _____to disclose the following information from the health records of:

   Patient Name: _____Date of Birth: _____

   Address: _____

   Soc. Sec. # _____ Telephone: _____ Med. Rec. #_____

2. **Dates of treatment/visit**:

   From (date) _____ to (date)_____

3. **Information to be disclosed:**

   - ☐ complete health record
   - ☐ discharge summary
   - ☐ history & physical
   - ☐ ER record
   - ☐ consultation report (s)
   - ☐ operative report
   - ☐ lab report (s)
   - ☐ pathology report
   - ☐ x-ray report (s)
   - ☐ cardiopulmonary report (s)
   - ☐ other (please specify) _____

   Information disclosed to:

   _____

   _____

   _____

   _____

   Purpose of Release: _____

   I understand that this will include information relating to (**check if applicable**):

   - ☐ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
   - ☐ Behavioral health services/psychiatric care
   - ☐ Treatment for alcohol and/or drug abuse

4. I understand that my records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date of my signature.

   The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information other than to the extent indicated and authorization herein.

_____ _____

Signature of patient / legal representative **Date**

114178 Rev. 5/03

Confirmed ID ____

DOB: // **Admit: //** **:00**

Physician: , -

ADHIGNRL