Date of Request:	Patient Name:		D	ate of Birth:		
The information to be released:						
Dates of service to be released:	I hereby authorize Cape Regional	Medical Center to r	elease/obtain con	fidential inform	nation to/from:	
Information to be released (Must be Specific): Discharge Summary History & Physical Consultation(s) Progress Notes Orders Operative Report Pathology	The information to be released:	Inpatient	Outpatie	entE	mergency Room	
Consultation(s) Progress Notes Orders Operative Report Pathology Medication Records Nursing Reports Discharge Instructions Xrays/Imaging Laboratory Tests Therapy Records (PT, OT, ST) EKG Entire Record Emergency Department Billing Records Visit History Other (Specify) The information indicated above is to be released for the purpose of. Insurance Legal Workers' Compensation Employer Personal Study/Research Transfer Other (Specify) Notice to the Recipient of Record: This information has been disclosed to you from records protected by Federal laws of privacy and confidentiality (42 CFR Part 2 and 45 CFR Parts 160-164). I understand that the information in my health record may include information relating to the testing or treatment of sexually transmitted disease, HIV/AIDS, behavioral or mental health services, alcohol and drug information, genetic information, and tuberculosis. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Privacy Officer at Cape Regional Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will remain in effect for a period of one year from the date stated below unless revoked. These laws prohibit you from making any further disclosures of these records, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by law. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality and p	Dates of service to be released:					
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of telfax.	These laws prohibit you from making permitted by written authorization authorizing the disclosure of this has form in order to assure treatment. It provided in CFR 164.524. 1 unders redisclosure and the information m	ng any further disclos by the person to whor ealth information is vo understand that I may tand that any disclosu ay not be protected by	oures of these reconnit pertains or as obluntary. I can refur inspect or copy to the of information of federal confidents	rds, unless furthootherwise permiuse to sign this and the information to carries with it the infillity and privace	tted by law. I understand that uthorization. I need not sign this o be used or disclosed, as e potential for an unauthorized by regulations. If I have	
Signature of Patient or Legal Representative Date Witness Signature		may be released via	the U.S. Postal Se	rvice, an overnig	ght delivery service, or by way	
	Signature of Patient or Legal Repr	esentative	Date	Witness Signa	ture	
If Signed by Legal Representative, Relationship to Patient	If Signed by Legal Representative	, Relationship to Patic	ent			
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS