Patient Name: _____ Date of Birth: _____

Date of Request: _____ Medical Record #- _____

I hereby authorize Cape Regional Medical Center to release/obtain confidential information to/from: _____

_____

The information to be released: _____ Inpatient _____ Outpatient _____ Emergency Room

Dates of service to be released: _____

Information to be released (Must be Specific): _____ Discharge Summary _____ History & Physical
_____ 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. _____ Continuity of Care
_____ 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). 1 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. 1 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 privacy regulations. If I have questions about the disclosure of my health information I can contact the Privacy Officer at Cape Regional Medical Center.

I also understand that these records may be released via the U.S. Postal Service, an overnight delivery service, or by way of telfax.

_____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

_____

If Signed by Legal Representative, Relationship to Patient

CAPE REGIONAL
MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS