LITTLE RIVER HEALTHCARE
KING'S DAUGHTERS CLINIC

Official Use Only:
Date mailed: _____
Date faxed: _____
Picked-up: _____
By: _____
Contact #: _____

☐ *If information has already been requested by the provider's office, please check this box*

Authorization for Release of Medical Information

Patient Name:_____(Maiden) _____DOB:_____

Contact #:_____Patient's SSN:_____

Address:_____City:_____State:_____Zip:_____

I authorize and request that a copy of the following information from my medical record be released as follows:

FROM: _____
_____
_____
_____
_____

TO: _____
_____
_____
_____
For Physician:_____

PLEASE CHECK INFORMATION TO BE RELEASED:

☐ Progress Notes	☐ History and Physical	☐ Nurses Notes
☐ Medication Records	☐ Lab Report	☐ Billing
☐ Emergency Room Record	☐ Pathology Report	☐ Immunization Record
☐ Operative/Procedure Note	☐ X-Ray Report	☐ Review Medical Record Only
☐ Discharge Summary	☐ EKG, EEG, EMG	☐ Other (Specify)_____

INCLUDE INFORMATION (if applicable) PERTAINING TO:

☐ Psychiatry/Psychology ☐ Drug ☐ Alcohol ☐ HIV/AIDS

PURPOSE OF DISCLOSURE:

☐ Attorney/Legal	☐ Continued Patient Care	☐ Personal Use
☐ Commercial Insurance	☐ Worker's Compensation	☐ Other (Specify)_____

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person. This consent will expire six (6) months after the date of my signature.

If information is being released directly to me, I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I will not hold Little River Healthcare-King's Daughters Clinic liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation.

I understand that I may revoke this authorization in writing at any time except to the extent that Little River Healthcare-King's Daughters Clinic has already relied on this authorization. I understand and I may revoke this authorization by providing the Little River Healthcare-King's Daughters Clinic Release of Information Department a written request for revocation that must clearly state my intention to revoke this authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness

☐ Signature Verified by DL Comparison
☐ Copy of Picture ID Obtained