KSB HOSPITAL
KATHERINE SHAW BETHEA HOSPITAL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information

____ ____/____/____
First Name Last Name Maiden/Other Name(s) Date of Birth

____ (____)____________
Address Phone Number

____
City State Zip Code

Release Information From

***Release of Medical Records* From:**

____
Name

____
Street Address

____
City State Zip Code

***Release of Medical Records* To:**

____
Name

____
Street Address

____
City State Zip Code

Medical Records to Be Released

____/____/____
Requested Delivery Date

____/____/____ to ____/____/____
Medical Records Requested for Dates of Services
(if no dates listed, records will includ past 24 months)

Please Check All That Apply:

- ☐ **Emergency Room Visit** (ER Notes, progress notes, consultations, procedure notes, test results)
- ☐ **Hospital Stay** (History and physical, progress notes, consultations, operative reports, discharge summary, test results)
- ☐ **Outpatient Surgery/Procedure** (History and physical, progress notes, consultations, procedure notes, test results)
- ☐ **Clinic, Office Visit, or Immediate Care** (Office notes, progress notes, procedure notes, test results)
- ☐ **Test Results/Reports Only** (check all that apply) ☐ Laboratory ☐ Radiology ☐ Other(Specify) ____________

Authorization

Expiration: The authorization will expire one year from date of authorization, unless otherwise revoked by the patient.

I understand that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results or information. ☐ Please Initial

I understand that I have the right to inspect and copy the information that is requested and to be released pursuant to this Authorization.

I understand that I may refuse to sign this authorization and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.

____
Signature of Patient or Legal Representative Relationship to Patient Date
(Patients ages 12 - 17 may be required to sign and date with co-signatrue of parent/legal guardian)

____
Co-Signature Relationship to Patient Date