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 _____

Email Address _____

Release Information From

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

KSB Hospital
403 E. First Street
Dixon, IL 61021

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

Name _____

Fax # _____ Phone # _____

Email Address _____

Medical Records to Be Released

Please Check All That Apply: **Date(s) of Service:** _____

- ☐ **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) _____
- ☐ **Records regarding Mental Health treatment**
- ☐ **Other**: _____

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 _____