Ohio Valley HOSPITAL

* A U T H M R *

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I hereby consent to authorize _____ to release information from
Health Care Facility

the medical record of: _____
Patient *Birthdate*

The information is to be disclosed to: _____
Person/Organization to whom information is to be released

_____
Address *City* *State* *Zip Code*

_____
Telephone Number *Fax Number*

and shall include information from the above-named facility's records, including photocopies relating to the patient's identity, diagnosis, prognosis, and/or treatment including:

_____ Entire Medical Record	_____Cardiology Report(s)	_____Lab Reports
_____Summary Sheet	_____Consultation(s)	_____Operative Reports
_____Discharge Summary	_____X-ray Reports	_____Therapy Report(s)
_____History & Physical	_____Stress Test	_____Respiratory Therapy Report(s)

The specific dates of such records to be disclosed include:

Beginning Date:_____ Ending Date:_____

The purpose or need for the release of these records is: _____
Describe purpose for which records are to be released

I, the undersigned, authorize Ohio Valley Hospital and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse records.
I also understand that information used or disclosed according to this authorization may be subject to subsequent disclosure by the recipient and may no longer be protected.
My failure to sign this authorization may result in my information not being released.

X_____ _____
Patient's Signature ***Date***

I understand that my signing this authorization will have no effect on my rights and responsibilities relating to my treatment, payment enrollment, or eligibility for benefits at Ohio Valley Hospital, I understand that I might be releasing to the person/organization identified above, information which is specially protected under provisions of state and/or federal law. I also understand that there is a potential for my protected health information to be redisclosed by the recipient of the information. I further understand that I may revoke this authorization at any time except to the extent that the person who is making the disclosure has already acted in reliance on this authorization. To revoke this authorization, I must advise the Information Management Department of Ohio Valley Hospital in writing at the above address or facsimile number of my revocation. I further understand that, if not revoked earlier, this consent will remain in force for 90 days.

X_____ _____
Patient's Signature ***Date***

X_____ _____
Signature of Parent/Legal Guardian/Authorized Representative ***Date***

X_____ _____
Signature of Authorized Representative ***Date***