Marshall Medical Centers

Many Reasons. One Choice.

AUTHORIZATION TO REQUEST HEALTH INFORMATION FROM OTHER FACILITIES

1. I hereby authorize _____ to disclose the following
(include name and address)
information from the health records of:

PATIENT NAME: _____ **MEDICAL RECORD NO.** _____

DATE OF BIRTH: _____**PHONE:** _____

ADDRESS: _____

Covering the period(s) of health care:
FROM (date): _____ TO (date): _____

2. Information to be disclosed:

- ☐ History And Physical
- ☐ Progress Notes
- ☐ Complete Health Record
- ☐ CT Scan
- ☐ Nuclear Medicine
- ☐ Emergency Room Report
- ☐ Physician Orders
- ☐ Prenatal Record
- ☐ MRI
- ☐ Special Procedure
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Anesthesia Record
- ☐ Ultrasound
- ☐ Consultation Reports
- ☐ EKG
- ☐ X-Rays
- ☐ Mammography
- ☐ Photographs, Videotapes, Digital or Other Images
- ☐ Laboratory Tests (please specify) _____
- ☐ Other (please specify) _____

If applicable, I also give permission for the following to be disclosed **(please initial):**
_____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
_____ behavioral health services/psychiatric care
_____ treatment for alcohol and/or drug abuse

3. This information is to be disclosed to Marshall Medical Center _____.

4. 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 my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days.

5. I 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 rules. If I have questions about disclosures of my health information, I can contact the privacy officer at Extension 6638.

6. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

Signed: _____
(Patient) (Date)

_____
or (Legal Representative) (Relationship to Patient) (Date)

_____
(Signature of Witness) (Relationship to Patient) (Date)

Patient ID: _____

Return to: Health Information Management, Marshall Medical Centers,
227 Brittany Road, Guntersville, AL 35976 or fax to 256-894-6636

Effective 5/2014