



MEDICAL RECORDS RELEASE FORM OF MEDICAL INFORMATION

PATIENT NAME _____

MAIDEN NAME _____ ADDRESS: _____

DATE OF BIRTH _____	SOCIAL SECURITY NO _____	TELEPHONE _____
I hereby authorize and request release of records by:		To release to Sacred Heart Health System:
Name (Hospital, Clinic, Physician)		Department of Radiation Oncology
Address		1545 Airport Blvd – Suite 1000
City	State	Zip
Phone#	Fax#	Pensacola FL 32504
City	State	Zip
Phone#	Fax#	

A copy of the medical records of the above-named patient pertaining to: (Check appropriate box and list the date)

- Emergency Care, Date: _____
 Hospitalization, Date: _____
 Outpatient Care, Date: _____

CHECK APPROPRIATE BOXES: (please check one)

- | | | |
|--|--|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Physical Therapy Notes | <input type="checkbox"/> Lab | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Pathology | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Abstract (H&P, discharge summary, consult, OP report) | | |
| <input type="checkbox"/> Other: _____ | | |

REQUIRED: The purpose of the request for Medical Records is:

- at the request of the patient; for diagnosis/treatment purposes; other. Explain _____

REQUIRED: _____ I DO _____ I DO NOT authorization the release of information, including, if applicable, specific laboratory tests of HIV Infection (Human immunodeficient Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

- Releasor, its agents and employees, are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieve of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this Authorization.
- This authorization will expire one (1) year from the date of my signature.
- I understand that I have the right to revoke this Authorization, if the revocation is in writing except if (i) Releasor has taken action in reliance upon this Authorization, or (ii) if this authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
- I understand that I may revoke this Authorization by providing a written revocation to the provider from which records are requested in the box above.
- I understand that my Protected Health Information (PHI) that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my PHI may no longer be protected by law.

Signature of Patient

Date

Authorization Representative, If Patient unable to Sign

Description of Authorization Representative

Witness

Date