WASHINGTON COUNTY MEMORIAL HOSPITAL

Washington County Memorial Hospital
300 Health Way Drive
Potosi, MO. 63664
Phone 573-438-5451
Fax 573-438-7916

Patient Medical Record Number:

I hereby authorize Washington County Memorial Hospital to release medical information of:

Patient's Full Name:_____

Former Name(s) (where applicable):_____

Date of Birth:_____ Social Security Number:_____

I request **only** the following information to be released/obtained:

- ☐ Emergency Report
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Radiology Disc/Film
- ☐ Mammogram
- ☐ EKG
- ☐ Itemized Billing Statement
- ☐ Other (specify)_____

Date(s) of Treatment:_____

Release/ Mail To:_____
(Individual/Physician/Institution/Agency)

_____
(Street/P.O. Box Address)

_____
(City, State & Zip Code)

_____
(Telephone Number)

For the purpose of:_____

ATTENTION: Once this information has been released pursuant to this authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that Washington County Memorial Hospital cannot make me sign this authorization as a condition to getting treatment, making a payment on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a copy of the authorization if I chose to do it.

I understand that I may revoke this authorization at any time. This authorization will expire in 120 days from the date it is signed if I do not cancel it in writing prior to expiration date. I understand that if I want to cancel/revoke this authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of this page. I hereby acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the HIPAA Rule.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative.

_____ _____
(Signature of Patient/Legal Guardian/Personal Representative) (Date)

_____ _____
(If someone else signs on behalf of patient, state relationship to patient) (Date)

_____ _____
(Witness) (Date)