Saline Health System

Authorization for Release of Medical Information

Saline Health System is hereby authorized to allow _____
(Name & Address)
to review and obtain copies from the medical record of _____.
(Patient's Name)
Date of Birth _____ Social Security # _____

Medical Record Number _____

Hospital Visit Date _____ for the purpose of _____

Information Requested

___ ER Report ___ History & Physical ___Lab Report ___ Discharge Summary

___ Operative Report ___ Consultation Report ___Pathology Report ___ Birth Records

___ Radiology Films ___ Radiology Report ___ Complete Record ___ Other _____

Information to be received via

___ Physical copy to individual ___ Fax _____
(Fax Number)

___ Mail _____
(Address)

___ E-Mail _____
(E-Mail Address)

E-Mail will be sent unencrypted, which is not a secure method of communication. By requesting records by e-mail, you are acknowledging that you understand the risk and accept the responsibility of records being sent unsecured. _____ (Initial)

(Special authorization to release medical information under the drug abuse office and treatment act of 1972 {public law 92-255} and the comprehensive alcohol abuse and alcoholism prevention treatment and rehabilitation act amendment of 1974 {public law 93-282}).

Date: _____ **Signature:** _____

In the event of a minor or incompetent individual:
Relationship to patient: _____

(Office Use Only)

Date Copied: _____ Date Picked Up: _____
Witness: _____ Witness: _____
(Attach Copy of Picture ID)
Radiology Films: Study # _____ Date(s) _____
_____ Mailed _____ Picked up by Ambulance _____ Other _____