Saline Memorial HOSPITAL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Saline Memorial Hospital is hereby authorized to allow_____

(Name & Address)

to review/remove copied portions from the medical record of_____

(Patient)

Date of Birth_____ SS #_____

Medical Record Number_____

Hospital Visit Date_____

for the purpose of _____.

INFORMATION REQUESTED

___Radiology Films	____History & Physical	___Lab Report
___Discharge Summary	____Operative Report	___ER Report
___Consultation Report	____Radiological Report	___Complete Record

___Other (Please Specify)_____

(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 REHABILITATIN ACT AMENDMENT OF 1974 (PUBLIC LAW 93-282).

A signature on this form will also authorize the release of alcohol and/or drug related information, and may be revoked in writing at any time prior to the release of information.
Unless revoked in writing, this authorization will expire six (6) months from the date of this authorization.

Date:_____ Signature:_____

In the event of a minor or incompetent: Sign_____

(Next of Kin)

Relationship:_____

(Office Use Only)

Date Copied:_____ Date picked up:_____
Witness:_____ Witness_____

(ATTACH COPY OF PICTURE I.D.)

RADIOLOGY FILMS: STUDY #_____DATE(S)_____
_____MAILED _____PICKED UP BYAMBULANCE