# LIVINGSTON HOSPITAL

131 HOSPITAL DRIVE
SALEM, KY 42078
(270) 988-2299

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, DOB ____/____/____, do hereby authorize
(Name of Patient)
_____, to disclose to _____
(Name of Provider)

for the purpose of _____ information from the health/medical records relating to my identity, diagnosis, prognosis, and/or treatment. This release includes the approximate time period from: ____/____/____ to ____/____/____, information to be disclosed includes:

_____ Entire Medical Record
_____ Emergency Room Record
_____ Face Sheet
_____ Lab, Pathology, or Radiology
_____ To view chart only _____

_____ History and Physical
_____ Operative Record
_____ Other (SPECIFY)

NOTICE: This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS information. Such records will be disclosed unless you specify information you wish to be excluded.

EXCLUSIONS: _____
I give special permission to release any information regarding: (initial on line(s) below that you grant us permission to release the information to the above)
_____ Substance Abuse _____ Psychiatric/Mental Health _____ HIV Information

In accordance with House Bill #250, your first medical record copies have been provided free of charge. Subsequent copies will be charged according to the current hospital fee schedule. Your signature below verifies your understanding of the above statement.

I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and this consent will remain in force for:

_____ 60 days _____ Specify other

Date: ____/____/____

_____
Patient

_____
Witness

_____
Patient, Guardian, Legal Representative

_____
Relationship to Patient