Community Health Partners℠
PHYSICIAN HOSPITAL ORGANIZATION

Consent for Release of Medical Record Information

PATIENT'S NAME: _____ **SSN #:** _____
ADDRESS: _____ **DATE OF BIRTH:**_____
_____ **MEDICAL RECORD #:** _____
CHP PRODUCT: _____ **DISCHARGE DATE:** _____

I hereby request and authorize _____ to release to Community Health Partners

The medical records of _____ as more specifically provided below.
(Name of patient)

I understand and acknowledge that certain information which may be contained in the medical records requires specific authorization for disclosure, and, except as otherwise provided by law, such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information includes information pertaining to (i) treatment for mental or emotional conditions, (ii) alcohol/drug abuse or (iii) HIV testing test results.

I hereby authorize the release of the information indicated below to the person named above for the purpose of :_____.

Information to be released/disclosed (check all that apply):

( ) **Entire Medical Record** (<u>including</u>, if any, mental health information, substance abuse information, HIV testing information and results).
( ) **Entire Medical Record** (<u>excluding</u>, if any, mental health information, substance abuse information, HIV testing information and results).
( ) Laboratory Results
( ) Consultations
( ) M.D. Progress Notes
( ) Diagnostic Studies
( ) Final Summary
( ) CABG Report(s)
( ) Cardiac Cath FILMS
( ) Pathology Report(s)
( ) Operative Report(s)
( ) History & Physical
( ) Radiology Report(s)
( ) HIV Testing & Results
( ) Alcohol/Drug Abuse Information
( ) Other _____
_____

I do hereby agree to release, indemnify and hold harmless, Community Health Partners, its board members, directors, employees, agents and members of its medical staff, from and against any claims against or liabilities incurred by it or any time, arising out of or in connection with the disclosure of medical information authorized to me pursuant to this consent.

THIS CONSENT MAY BE REVOKED AT ANY TIME, EXCEPT TO THE EXTENT THAT THE RECEIVING FACILITY HAS ALREADY TAKEN ACTION IN RELIANCE ON IT. THIS CONSENT AND AUTHORIZATION SHALL AUTOMATICALLY EXPIRE 365 DAYS FROM THE DATE OF THIS CONSENT, UNLESS REVOKED BY THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE PRIOR TO THAT TIME.

_____ _____
(Signature of Patient or Authorized Representative) (Print Name)

_____ _____
(Relationship to Patient) (Date)

For Department Use Only:
Released by: _____ **Date:** _____