



MOUNT CARMEL
HEALTHPROVIDERS, INC.

MEDICAL RELEASE OF INFORMATION

AUTHORIZATION

I hereby authorize _____ to release any and all medical records, including but not limited to hospitalization for diagnosis and/or treatment of psychiatric and/or mental condition, alcoholism, drug abuse and/or HIV test results, AIDS, or AIDS related conditions:

Release to: _____

Address: _____

Address: _____

USES

The purpose of the release of this information is:

- Continuity of Medical Care Pending Legal Action
- Other: (Specify) _____

RESTRICTIONS

The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization will expire 60 days from today or at an earlier date, at my election (To cancel this authorization prior to the above limit, notification must be sent to the Medical Record Department in writing and bear the patient's or legal representative's signature).

PATIENT INFORMATION

Please Print

Patient's Name: _____

Date of Birth: _____ Social Security # _____

Date(s) of Treatment: _____

SIGNATURES

Patient's Signature: _____ Date: _____

Legal Representative's Signature: _____ Date: _____

Witness Signature: _____ Date: _____