



CCMC	Springfield
DCMH	
Taylor	
CKHN	

Authorization to Release Medical Information.

Patient Name: _____ Date: _____

Social Security Number _____ Date of Birth _____

I authorize the release of my health information to:

Information to be released and Date(s) of Service _____

- Complete medical record (inpatient, outpatient, Emergency)
- Laboratory Pathology
- Radiology (report, film) slides
- Operative Report
- Discharge Summary
- Other _____

***I give my permission for the following information to be released. (please check and initial)**

- HIV related information _____
- Alcohol/Drug Treatment information _____
- Mental Health _____
- Psychotherapy Notes _____

Reason for Disclosure

The information is being released for:

Please Read

- This facility will not receive financial compensation in exchange for using/disclosing the health information described.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive treatment or payment or my eligibility for benefits. I may read or copy any information used/disclosed under this authorization and I understand there is a