

DODGE COUNTY HOSPITAL

CONSENT FOR RELEASE OF MEDICAL INFORMATION

TELEPHONE NUMBER _____

* I hereby authorize the _____ to release the indicated information from the health record(s) of:

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____

cover the period(s) of hospitalization:

ADMISSION DATE _____

DISCHARGE DATE _____

Other treatment dates _____

* Information to be released:

_____ History and Physical _____ Operations Records

_____ Discharge Summary _____ Pathology Reports

_____ Lab/X-Ray Reports _____ Complete Records

Other: _____

* INFORMATION TO BE RELEASED TO: _____

* For the purpose of: _____

* I understand that I may withdraw this authorization with written notice except to the extent that action has been taken based on my consent.

SIGNED _____

Patient, or if minor, parent or guardian

DATE _____

*I hereby specify that this authorization to release information extends to cover release of information related to HIV-III testing, the result(s) of testing, counseling, and/or treatment of AIDS, AIDS Related Complex (ARC) or AIDS related conditions.

SIGNED _____

Patient, or if minor, parent or guardian

* I hereby specify that this authorization to release information extends to cover release of information related to psychiatric and/or drug and alcohol abuse treatment information.

SIGNED _____

Patient, or if minor, parent or guardian

Disclosure of Medical Record information by the recipient is prohibited except when implied in the purpose of this disclosure.

This authorization is not valid if presented more than 90 days after date signed.