



The James B. Haggin Memorial Hospital

464 Linden Avenue
Harrodsburg, KY 40330

AUTHORIZATION FOR RELEASE OF INFORMATION

Please read carefully before completing: Please provide all of the information requested in the blanks below. If psychiatric, psychological, and/or drug/alcohol abuse information is being requested, this must be specified in the space labeled "other" and the purpose for requesting the information must be specified.

I, _____, Birthdate _____ do hereby authorize
(name of Patient)

_____ to release the information specified below:
(name of organization releasing info)

(Be as specific as possible of the dates of treatment below)

- | | |
|----------------------------|------------------------------|
| _____ Discharge Summary | _____ X-Ray Reports |
| _____ History and Physical | _____ Lab Reports |
| _____ Operative Reports | _____ Consultation Reports |
| _____ Pathology Reports | _____ EKG, Treadmill, Holter |
| _____ Entire Record | _____ Other (please specify) |
| _____ Free Copy | |

_____ No limitations placed on information released. This includes any information regarding drug and/or alcohol abuse and HIV/AIDS information.
(Signer must initial for authentication of this response.)

- | | |
|-----------------------------------|--|
| _____ Personal Interest | NAME AND ADDRESS OF PERSON/AGENCY TO WHOM INFORMATION IS TO BE RELEASED

_____ |
| _____ Use in continuation of care | |
| _____ Use in insurance processing | |
| _____ Use in legal claim | |
| _____ Disability Determination | |
| _____ Other (specify) | |

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on actions taken before the organization received the revocation.

Date _____ Patient's Signature _____

If someone other than the patient signed above, please state the relationship to the patient and the reason for signing in lieu of the patient: _____

This authorization will expire 90 days from the above date. Any disclosure of Medical Information by the recipient(s) is prohibited by Federal Law.

Person releasing records _____

Signature