Midwest Regional Health Services

Release of Information

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NAME: _____ Birthday: _____

ADDRESS: _____ Contact #: _____

_____ SSN #: _____

I hereby authorize and request release of my: (select medical and/or behavioral health records)

☐ Behavioral Health Records (all treatment notes)

☐ Medical Records

- ❑ ALL Medical Records
- ❑ Medical Records for dates _____ to _____
- ❑ Specific information to be released (Check all that apply)

_____ Discharge Summary	_____ Consult Notes	_____ Emergency Room Records
_____ Radiology Reports	_____ EKG/EEG	_____ Operative Report
_____ History & Physical Exam	_____ Echocardiogram	_____ PT/OT Therapy Notes
_____ Clinic Notes	_____ Pathology Report	_____ Laboratory Results

_____ Other (Name) _____

FROM:_____ Phone/Fax: _____

TO: _____ Phone/Fax:_____

Purpose of Release: ____Medical Care ____ Personal Records ____ Attorney ____Other

This statement of consent can be revoked at any time before disclosure of the information, and expires, in any event, one year after it is signed. Date of expiration: _____

I understand that I may revoke this authorization at any time before by notifying the providing organization in writing. If I revoke the authorization, it will not have effect on actions taken prior to receipt of this revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protected by those regulations.

_____ _____
Signature of Patient Signature of Parent/Guardian/Authorized Representative

_____ _____
Date Relationship of personal above to patient