LAKE BUTLER HOSPITAL

850 East Main Street • Lake Butler, FL 32054

Authorization To Release Medical Information
(If under 18 years of age, parent or guardian must sign)

Name of Patient:	Patient ID #:	Date of Service:
Patient address:	Date of Birth:	Phone:

I authorize and request the release of medical records FROM Lake Butler Hospital and wish to disclose same to:

Name:_____ Address: _____

City/State: _____ _____ Zip: _____

For the purpose of:

☐ Continuation of medical treatment
☐ Personal use
☐ Payment of bill
☐ Legal or insurance purposes
☐ Worker's compensation

The information to be disclosed is:

Please mark box and provide date of service:

☐ Discharge Summary: _____ ☐ Operative reports: _____ ☐ History & Physical:_____
☐ X-ray Reports: _____ ☐ Laboratory Reports: _____ ☐ Pathology Reports: _____
☐ Consultations: _____ ☐ Other (Specify) _____

_____(Initial) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), hum immunodeficiency virus (HIV) or hepatitis. It may also include information about behavior or mental health services and treatment for alcohol and drug use.

_____(Initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about, or medical records of my medical condition to those persons or agencies named above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original.

_____(Initial) The staff of Lake Butler Hospital may leave discrete messages on my personal answering machine or at another number that I provide.

If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/she should put an X on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

This authorization for release of information expires in one year after the date of signature.

I understand that this consent is revocable by me, in writing, at any time except to the extent this action has been taken in reliance to it.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

_____ _____ _____
Consenting party signing in lieu of patient Relationship Date