900 N. 2nd St.
Rochelle, IL 61068
Phone: 815-562-2181
Fax: 815-561-3124

Date of Request: _____

Authorization for Disclosure of Medical Record Information

Patient Name: _____ Med. Record No. _____

Date of Birth: _____ Social Security No. _____

The undersigned hereby authorizes *Rochelle Community Hospital* to furnish to:

Name: _____ Telephone: _____
Address: _____
For the purpose of: _____

Information/copies contained in the medical record relative to hospitalization and/or treatment, including but not limited to, examination, diagnosis, evaluation, treatment or rehabilitation. Access to this information is limited as specified below:

Beginning Date: _____ through _____

Release only those portions of the medical record checked/listed below:

_____ Complete Health Record	_____ Operative Report	_____ X-ray Films
_____ Lab Reports	_____ Consultations	_____ Face Sheet
_____ History & Physical	_____ Emergency Room Reports	_____ Discharge Summary
_____ ECG	_____ Blood Alcohol Results	_____ Progress Notes
_____ Transfer Forms	_____ X-ray Reports	_____ Other, specify: _____

I fully understand that my medical record and/or information in connection with the hospitalization/treatment dates stated above may contain test results/treatment/diagnosis or other information relative to (check if applicable):

_____Mental Health Records _____Substance Abuse Records _____ HIV/AIDS Records _____ Sexual Assault/Abuse

I understand that if I refuse to consent to the release of the above requested information it will prevent the disclosure of the information. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

This authorization expires ninety (90) days from the date signed. I understand that I have the right to revoke this authorization by giving written notice to the Health Information Management Department at *Rochelle Community Hospital*.

Rochelle Community Hospital and its employees, attending physicians, and agents are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient's Signature: _____ Date: _____
(Name of Patient)

Co-signature: _____ _____ Date: _____
(Parent/Guardian) (Relationship)

If signed by other than patient, state reason: _____

Witness Signature: _____ Date: _____

NOTE: *Newborn through age 11:* Parent/legal guardian must sign and date.
Ages 12 through 17: Patient and parent/legal guardian and witness sign and date for confidential information.
Emancipated minors: May sign and date for themselves - if they show proof of emancipation.
Age 18 and over: Patient must sign and date for self unless adjudicated incompetent.