PATIENT NAME: Date of Birth:

Date of Request: Medical Record #:

I hereby authorize Cape Regional Medical Center to release/obtain confidential information to/from:

The information to be released Inpatient Outpatient Emergency Room

Dates of service to be released:

Information to be released (Must be specific: Discharge Summary History & Physical

Consultation(s) Progress Notes Orders Operative Report Pathology

Medication Records Nursing Reports Discharge Instructions Laboratory Tests

Therapy Records (PT, OT, ST) EKG Entire Record Emergency Department

Billing Records Visit History

Other (Specify)

Xrays/Imaging

Dates and description of Xrays to be released:

The information indicated above is to be released for the purpose of: Continuity of Care Insurance

Legal Worker's Compensation Employer Personal Study/Research

Transfer Other (Specify)

Notice to the Recipient of Record: This information has been disclosed to you from records protected by Health Insurance Portability & Accountability Act (HIPAA), Federal laws of privacy and confidentiality (42 CFR Part 2 and 45 CFR Parts 160-164). 1 understand that the information in my health record may include information relating to the testing or treatment of sexually transmitted disease, HIV/AIDS, behavioral or mental health services, alcohol and drug information, genetic information, and tuberculosis.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Privacy Officer at Cape Regional Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will remain in effect for a period of one year from the date stated below unless revoked.

These laws prohibit you from making any further disclosures of these records, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by law. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. 1 understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by the HIPAA Federal confidentiality and privacy regulations. If I have questions about the disclosure of my health information I can contact the Privacy Officer at Cape Regional Medical Center.

I also understand that these records may be released via the U.S. Postal Service, an overnight delivery service, by way of telefax, or electronically.

Signature of Patient or Legal Representative Date Witness Signature

If signed by Legal Representative, Relationship to the Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CAPE REGIONAL
MEDICAL CENTER