

MORTON GENERAL HOSPITAL
PO BOX 1138 – 521 ADAMS AVE
MORTON, WASHINGTON 98356
PHONE (360) 496-3545 FAX (360) 496-3543

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The patient (or person authorized by law) must complete and sign this form. There are separate and distinct portions of this authorization. Please read and fill out this form completely before signing your name.

(Please PRINT Name and Date of Birth) I, _____ BORN _____ / _____ / _____
Phone # _____

Authorize MORTON GENERAL HOSPITAL to release a copy of my medical information to:

(Please PRINT Name and Address of recipient)

The Information will be used for the following purpose(s): (Please circle one of the following choices)

Personal Attorney Insurance Payment of bill

Other _____

- Individual signing authorization agrees to pay all charges as allowed by law with copying of record(s).
- Morton General Hospital will not withhold treatment for patient if the patient or authorized person refuses to sign this authorization. The patient/individual may refuse to sign this authorization.
- I understand the privacy rule may no longer protect the health information released when it is disclosed to the recipient or to an authorized third party.

Please indicate by initialing each space authorizing release of the specific medical information requested: If space(s) are not initialed, information will not be released:

___ ER record(s) dated: _____ ___ All hospital records
___ Billing statements ___ LAB/Pathology reports ___ Nursing notes
___ MD reports (Dictation) ___ X-Ray Imaging reports ___ Physical Therapy notes
___ MD orders ___ X-Ray films ___ Social Worker reports

<u>SPECIFIC RELEASE</u> ___ STD info ___ HIV/AIDS info ___ Drug/Alcohol ___ Mental Health Info
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OTHER: _____

This authorization may be revoked at anytime by written, signed and dated notice to the address above. The only exception is if action has already been taken.

Please provide an expiration date. If no expiration is provided this authorization will expire 90 days from date of signature. Expiration date: _____

TODAYS DATE: _____ SIGNATURE OF PATIENT: _____

Signature of person authorized by law if not patient: _____

(Individual signing must show legal documentation of authorization.)

Relationship: _____

Date completed : _____ Type of ID verified (Driver's Lic. etc): _____

Morton General Hospital will not release requested medical information if this form is altered or incomplete as required by state and federal law.

Signature of staff member accepting / verifying completed ROI: _____