UNIT RECORD # : ____________________
PATIENT NAME: ____________________
BIRTHDATE: ____________________
ADMISSION DATES: ____________________

# PATIENT'S CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

**MHSC**

**Your name and address**

____________________
____________________
____________________

**Email-**

I request and authorize the above-named health care provider to release the information specified below to the organization / agency / individual I have specified in this request.

_____ Copy of complete medical record
_____ Copy of H&P, discharge summary, & operative reports
_____ Other, specify ____________________

Purpose of disclosure: ____________________

I authorize the release of information which may include information regarding the following:

_____ Drug abuse, if any
_____ Alcohol abuse, if any
_____ HIV, if any
_____ Psychiatric conditions, if any

ID Verified

I make this consent upon the promise that all disclosures made pursuant to the authority granted by this consent shall be accompanied by a written notice which states:

> "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.:

This consent for release of confidential information expires in twelve (12) months, or as authorized by me. Expiration date cannot exceed forty-eight (48) months and will cover only information created twelve (12) months after authorization is signed. I understand I may revoke this Authorization at any time, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, and the attending physician are hereby released from legal responsibility or liability for the release of the above information.

| | |
|---|---|
| Date | Signature of Patient |
| Signature of Releaser | OR Legally responsible person |
| Expiration Date (Not to exceed 48 months) | Specify Relationship |

Original - Chart    Copy - Patient