

CRITTENDEN MEMORIAL HOSPITAL
200 Tyler Avenue
West Memphis, AR 72301

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ SSN: _____

I authorize Crittenden Memorial Hospital to disclose to or to obtain from:

Name of Individual or Organization Authorized to Receive or Release Information

Address of Individual or Organization Authorized to Receive or Release Information

Please specify purpose: • Attorney, • Insurance, • Physician Consultation, • Personal, • Other

Please specify other purpose: _____

I authorize release of information covering treatment on the following dates of service:

Date (s) of Service

- **Abstract Only** (Demographic Sheet, History and Physical, Discharge Summary, Operative Report, Emergency Room Record, and Pathology Report, if applicable)
- **Entire Record**
- **Accounting of Disclosures**
- **Other** Please specify: _____

I release Crittenden Memorial Hospital (CMH) from any liabilities, damages, or claims, which might arise from disclosure of this information. This authorization also includes the release of any records related to the diagnosis and/or treatment of any psychiatric or mental illness, infectious diseases such as HIV/AIDS, and alcohol and/or substance abuse.

Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining authorization.

This authorization will automatically expire ninety (90) days from the date executed. I understand that I may revoke this consent to release/obtain medical information at any time. I also understand that any release made prior to the revocation and made in reliance upon this authorization shall not constitute breach of my right of confidentiality.

I understand that information disclosed pursuant to this authorization may potentially be re-disclosed by the authorized recipient and no longer protected by federal privacy laws.

Signature of Patient or Representative

Relationship

Date

Signature of Witness

Date

Identification Verified:

• Picture I.D. I.D. #: _____ Expiration Date: _____

• Signature Verified

Verified By: _____ Date: _____