

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Date of Birth (Mo/Day/Yr)

(Street address)

(City, state, zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize **The George Washington University Hospital** to release: **(patient's full name)**

- | | | |
|---|---|---|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> LABORATORY REPORTS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> DATES OF SERVICE _____ |
| <input type="checkbox"/> OPERATIVE NOTES | <input type="checkbox"/> ECG/EEG/CARDIAC CATH | <input type="checkbox"/> ENTIRE CHART |
| <input type="checkbox"/> VERBAL COMMUNICATION REGARDING BILLING | | |

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO:

NAME (Patient, Physician, Hospital, or other recipient)

Street address

City, state, zip

CHECK HERE for eDelivery (valid email address required) _____
(Please write legibly)

PURPOSE OF DISCLOSURE:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> REFERRAL TO SPECIALIST | <input type="checkbox"/> INSURANCE | <input type="checkbox"/> WORKERS COMP |
| <input type="checkbox"/> LEGAL INVESTIGATION | <input type="checkbox"/> DISABILITY DETERMINATION | <input type="checkbox"/> PERSONAL |

OTHER (SPECIFY) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or Personal Representative of patient's estate

Date



THE GEORGE WASHINGTON
UNIVERSITY **HOSPITAL**

Health Information Management

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RI0010

**Authorization for Release
of Medical Information**

74-128 (11/21)

Patient Label