AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Copy Services rendered by: **CIOX Health • Ph: 800-367-1500**

(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 _____ (patient's full name), do hereby authorize **The George Washington University Hospital** to release:

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ OTHER _____
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	_____ DATES OF SERVICE _____
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIAC CATH	_____ ENTIRE CHART

___ 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:

_____ REFERRAL TO SPECIALIST	_____ INSURANCE	_____ WORKERS COMP
_____ LEGAL INVESTIGATION	_____ DISABILITY DETERMINATION	_____ 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** _____

NOTE: CIOX Health is contracted to provide this service and will invoice you directly.

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

Health Information Management

900 23rd St., NW Washington, DC 20037 • Room G2036 • 202-715-5324 • Fax 202-715-4361

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Patient Label