CONSENT FOR RELEASE OF INFORMATION

This form authorizes release of your health information from King's Daughters Medical Center, its Family Care Centers and Urgent Care Centers to you or the people you choose.

1. Who is the patient?

Name _____ Date of Birth _____

Mailing Address _____

_____ Phone number _____

2. What information would you like to be shared?

- ☐ Entire medical record for all of your hospital stays.
- ☐ Radiology reports
- ☐ Laboratory results
- ☐ Emergency Room visit
- ☐ Only the records beginning on (date): _____
- ☐ Other Please describe: _____

3. What is the purpose of the information?

- ☐ Care or consultation elsewhere
- ☐ Insurance claim
- ☐ Legal matter
- ☐ Other: Please describe: _____

(Reason may be personal)

4. How would you like to receive the records? Records are available on a computer disc unless paper is requested.

- ☐ Picked up by you in person
- ☐ Picked up by someone you choose. If yes, who? _____
- ☐ Mailed to your home
- ☐ Mailed to another location? If yes, please fill in the name and address below.

_____

5. _____ Please read and initial that you understand the important information below.

- I understand that the records that are released may contain reference to: Alcohol/Drug Abuse, Psychiatric Information, HIV/AIDS, genetic information and STDs.
- I understand that I may withdraw this consent at any time by requesting to do so in writing. I understand KDMC cannot be held liable for any information released before withdrawing the consent.
- This authorization expires when the records have been released.
- I understand that if I release information to others, redisclosure of my health care may no longer be protected by Federal Privacy Laws.
- I understand that KDMC will not condition treatment or payment for care on whether I sign this authorization unless this authorization is necessary to participate in research.

Signature _____Date_____

Patient or Legal Representative (Proof of representation required)

Relationship, if not patient _____