RISING SUN MEDICAL CENTER, INC
Request and Authorization for Release of Medical Records

I (we), the undersigned, hereby request and authorize access to the indicated Medical Record for review, examination, and provision of such copies as may be requested.

PATIENT NAME: _____

ADDRESS: _____

BIRTHDATE: _____ PHONE: _____ SOC SEC: _____

The undersigned hereby authorized Rising Sun Medical Center to release and/or request the following portions of medical records of the named patient, via fax machine or Xeroxed copies. A facsimile signature will be considered an original for this purpose.

Check one below:

_____ Entire medical record, **including** mental health, alcohol or drug and/or **HIV/AIDS** information.

_____ Entire medical record, **with the exception of** information regarding mental health records, including alcohol or drug abuse and **HIV/AIDS** related treatment.

_____ The following specific portions of the medical record: _____

INDIVIDUAL / INSTITUTION

RELEASING INFORMATION	RECEIVING INFORMATION
Name _____	Name _____
Address _____	Address _____
_____	_____
_____	_____

The Medical Record information will be used and/or disclosed for the following purposes:

_____ At the request of the individual _____ Changing Primary Care Physician

_____ Other (write purpose here) _____

It is understood that this request and authorization may be revoked by me (us) at any time in writing except to the extent that action has been taken in reliance thereon. It is also understood that this consent will expire 90 days from the date signed or upon the subsequently specified date, event, or condition: _____

I (we) further agree that the Practice may charge me or any designated recipients the actual cost incurred in preparing the copy of the requested Medical Records.
It is understood that the foregoing is confidential information and will be considered as such. Furthermore, Rising Sun Medical Center is hereby released from any legal liability that might arise from release of such information.

_____	_____
Patient Name (print)	Social Security #
_____	_____
Patient Signature/Authorized Guardian	Date
_____	_____
Witness	Date

REORDER # 0500381