Calvert Memorial Hospital
Tradition. Quality. Progress.

CONSENT FOR RELEASE OF INFORMATION

1. I hereby authorize **Calvert Memorial Hospital/** _____ to release the following from the health record(s) of:

Patient Name/Address: _____ Date of Birth: _____

_____ Medical Record Number: _____

_____

covering the period(s) of hospitalization from: _____ _____ for the purpose of: _____
Admission Discharge

2. *Information to be released:*

General Medical Records

_____ Complete Record

_____ Abstract of Record to include DS, H&P, OP, Path, Lab, X-ray

_____ History and Physical

_____ Operative Report/Path Report

_____ Discharge Summary

_____ Test results

_____ Other, specify

_____

Psychiatric Medical Records ____Records/info sent ____Records/info not sent

_____Phone contact made _____ By Whom: _____
Date

_____ Psychological Assessment

_____ Psychological History and Physical

_____ Psychiatric Discharge Summary

_____ Letter to:

_____ Other, specify

_____

3. Information released to: (Name/Address) _____ Phone Number: _____

_____

_____

4. Authorization is valid until: _____ . This period may not exceed one (1) year. If left blank, authorization is valid for 3 months.

5. I understand this consent may be revoked, in writing only, at any time except to the extent that discloser made in good faith has already occurred in reliance on this consent.

6.The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

7. I acknowledge that the medical records that I authorize for release may contain information relating to my HIV status and/ or information related to drug and alcohol diagnosis and/or treatment.

Signed: _____ _____ INFORMATION RELEASED:
Patient or Representative Relationship to Patient

_____ _____
Date/Time Witness