The James B. Haggin Memorial Hospital

464 Linden Avenue
Harrodsburg, KY 40330

AUTHORIZATION FOR RELEASE OF INFORMATION

Please read carefully before completing: Please provide all of the information requested in the blanks below. If psychiatric, psychological, and/or drug/alcohol abuse information is being requested, this must be specified in the space labeled "other" and the purpose for requesting the information must be specified.

I, _____ , Birthdate _____ do hereby authorize
(name of Patient)

_____ to release the information specified below:
(name of organization releasing info)

(Be as specific as possible of the dates of treatment below)

_____ Discharge Summary
_____ History and Physical
_____ Operative Reports
_____ Pathology Reports
_____ Entire Record
_____ Free Copy

_____ X-Ray Reports
_____ Lab Reports
_____ Consultation Reports
_____ EKG, Treadmill, Holter
_____ Other (please specify)

_____

_____ No limitations placed on information released. This includes any information regarding drug and/or alcohol abuse and HIV/AIDS information.
(Signer must initial for authentication of this response.)

_____ Personal Interest
_____ Use in continuation of care
_____ Use in insurance processing
_____ Use in legal claim
_____ Disability Determination
_____ Other (specify)

NAME AND ADDRESS OF PERSON/AGENCY TO WHOM INFORMATION IS TO BE RELEASED

_____
_____
_____
_____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on actions taken before the organization received the revocation.

Date _____ Patient's Signature _____
If someone other than the patient signed above, please state the relationship to the patient and the reason for signing in lieu of the patient: _____

This authorization will expire 365 days (1 year) from the above date. Any disclosure of Medical Information by the recipient(s) is prohibited by Federal Law.

Person releasing records _____
Signature