MCHD – BREAST AND CERVICAL CANCER PROGRAM

Authorization for Release of Medical Records

Patient:_____ DOB:_____ SSN #_____

This is to authorize that the medical information regarding the above identified patient be released:

_____Copy of complete health record

_____Operative Report

_____History & Physical

_____Other (Explain)

Information to be released to:_____

Purpose of Disclosure:

I hereby authorize you to release health information for the above mentioned purpose. The facility, its employees and attending physician are released from legal responsibility for the release of the above information to the extent indicated and authorized herein.

_____ _____

Patient Signature Witness

_____

Date

This information is being disclosed to you from confidential records. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains and the facility from which the information originates.