MEMORIAL HEALTH SYSTEM

Marietta Memorial Hospital	Selby General Hospital
401 Matthew Street	1106 Colegate Drive
Marietta, OH 45750	Marietta, OH 45750
(740) 374-1400	(740) 568-2000

AUTHORIZATION FOR RELEASE OF INFORMATION

I ______________________________, hereby authorize Marietta Memorial Hospital to
(patient name)
release copies of medical and other information concerning my hospitalization or treatment including, but not limited to, information concerning drug abuse or drug-related conditions, alcoholism, psychological and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions or sexual preference, or permit review of same, provided, however that such release is limited specifically to material of the following nature and extent. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure resulting in my health information no longer being protected by Federal confidentiality rules.

Treatment Date:_________ ___Inpatient ___Emergency ___Outpatient
Patient Name:____
Date of Birth:____
Social Security Number:_________________________________

__Complete Chart __Operative/Pathology Report __Case Summary
__Face Sheet __Physician Orders/Progress Notes __Nursing Notes
__History/Physical __Emergency Room Report __Test Results
__Other____
Specific Exclusions:____

The above information is to be release to:
Person/Facility:_____________________________________
Address:____
Purpose of Disclosure:
__Insurance __Continuity of Care __Personal __Legal __Other______________________

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS
I understand this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire in one year after the date below or sooner at my election in which case this authorization will expire on _________________. I release the hospital of any liability which may arise as a result of any subsequent disclosure of my health information by the recipient.

______________________ ____
DATE SIGNATURE OF PATIENT

______________________ ____
WITNESS OTHER PERSON LEGALLY AUTHORIZED TO GIVE CONSENT

____
RELATIONSHIP

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general authorization for the release of medical and other information is not sufficient for this purpose.

According to State law there may be a per page fee charged for records. The fee will be dependent on the number of copies requested and other reasons as specified in ORC 3701.741 at www.codes.ohio.gov.