Sarah D. Culbertson Memorial Hospital

238 South Congress
Rushville, IL 62681
Phone: 217-322-4321
Fax: 217-322-2546
cmhospital.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize: Sarah D. Culbertson Memorial Hospital
238 South Congress Street
Rushville, IL 62681

To Release to: _____
Provider Name

_____
Address **City** **State, Zip**

The Medical Record: _____
of **Name of Patient** **Maiden Name**

_____
Present Address **City** **State, Zip**

_____
Birthdate **Telephone**

RECORDS AUTHORIZED TO BE RELEASED (PLEASE SPECIFY DATES): _____

☐ Complete hospital chart ☐ Emergency room report ☐ Admission Face Sheet ☐ Admission history and physical ☐ Discharge summary ☐ Physician progress notes ☐ Consultation notes, report outpatient clinic visit ☐ Report of operation ☐ Lab reports ☐ Radiological reports ☐ Radiological images ☐ EKG, echocardiogram, tracings, nuclear medicine ☐ Other (specify) _____	The following listed records are privileged information by law and can be released only upon specific consent. Designation and initials will be required for the release of these records. If specific records are not designated and initialed they will not be released. ☐ Sexually transmitted disease related information _____ ☐ HIV Related Information _____ ☐ Alcohol Abuse Related Information _____ ☐ Drug Abuse Related Information _____ ☐ Mental Health Diagnosis/Treatment Information _____

The purpose of this information is for:

☐ Transfer of treatment ☐ Consultation with other physician/facility for continuity of care	☐ Personal use ☐ Per physician request ☐ Other (specify) _____

Authorize the release of information via facsimile: I Do ____ I Do Not ____
Authorize the release of information via telephone (identity verified) I Do ____ I Do Not ____

I understand that my refusal to consent to the release of infomation will prevent the disclosure of the information and that disclosure will not be made without completion of this written authorization. I understand that I have the right to inspect the information that I authorize to be disclosed. I understand that I have the right to revoke this authorization at any time by writing to the Medical Reocrd Department of the releasing facility. I understand that my release which was made prior to any revocation in compliance with the authorization shall not constitute a breach of my rights to confidentiality. I understand that not withstanding revocation this release will expire (60) days after the date signed below.

_____ _____/_____
Patient Signature **Parent/Legal Representative Relationship**

_____ _____
Witness Signature **Date**

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Act, you may not disclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality and Alcohol and Drug Abuse Patient Records, no such records, nor information such records may be further disclosed without specific authorization for such disclosure.

***Persons who have Power to sign for privileged information: patient, age 18 or over (or guardian of person: parent/guardian and patient age 12-17 years; parent/guardian of patient under 12 years).**

REV 04/17/20 mls