McComb Police Department

Authorization for Release of Medical Information

Patient's Name: ______________________________ DOB: ____________ SSN: __________________

Address: ____

____
City State Zip Home Phone Number

Treatment Date(s): ____

I hereby authorize, request, and consent that the following medical facility(s) or provider(s), their agents and employees:

____

____

Release all medical information, records and communications, without limitation, including testimony regarding same, relating to my diagnosis and treatment on the above stated date(s); ***including*** treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, HIV test results or diagnosis of AIDS and or other communicable diseases. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be withdrawn at any time by written notification to the parties involved; however, if action has already been taken on my authorization, it cannot be withdrawn. I have read and fully understand the foregoing. This consent expires sixty (60) days from the date below, unless I indicate an earlier expiration date in this space ____.

This above information is to be ( ) released ( ) forwarded to:

____
Name Title

____
Name of Employer Address Phone

I have read and fully understand the foregoing. I consent to the disclosure of the medical records to the extent and for the purposes authorized by, ________________________________, McComb Police Department, 135 West Main Street, McComb, Ohio 45858.

________________________ ________________________ ____________
Patient's Signature Patients Printed Name Date

The patient is unable to sign this consent because he/she is:

( ) An unemancipated minor ( ) Deceased ( ) Other Reason (specify below)

____

The undersigned is the patient's: ( ) Parent ( ) Guardian ( ) Spouse ( ) Other:_____________

________________________ ________________________ ____________
Patient's Representative's Signature Patient's Representative's Printed Name Date

________________________ ________________________ ____________
Witness Signature Witness Printed Name Date

Rev. 05/05