Authorization to Release Medical Information

BeLoved Hospice, Inc.

Main: 971.236.1199

Email: info@belovedhospices.com

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone Number: _____

Other Alias(es): _____ Guardian or Legal Representative Name: _____

Phone Number: _____

I hereby authorize the below listed entity to release my medical information to BeLoved Hospice:

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

Medical Information Requested:

- ☐ All Records
- ☐ Admitting History
- ☐ Physical Examination and Assessment
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}
- ☐ Operative Reports

_____ _____

Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for five years from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Print Patient Name: _____ MR#: _____