



AUTHORIZATION FOR THE RELEASE OF LABORATORY MEDICAL INFORMATION
(Sections 2-15 must be completed.)

1. I hereby authorize Jordan Hospital to use or disclose the following health information from the laboratory records of the patient listed below. I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. PATIENT NAME _____ DATE OF BIRTH _____
ADDRESS _____ TELEPHONE NO. _____

3. LAB MEDICAL INFORMATION to be disclosed to: NAME _____
ADDRESS _____ TELEPHONE NO. _____

4. PURPOSE OF REQUEST _____

5. DATES OF INFORMATION REQUESTED _____

6. I understand I may revoke this authorization at any time by requesting such of the above-referenced hospital/physician/facility/ in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization expires after (90) ninety days from the date I signed it unless otherwise specified.

7. SIGNATURE _____ 8. DATE: _____
Patient/Legal Representative

9. PRINT NAME _____

10. I understand that my record may contain information in reference to treatment for substance and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social services notes, or other sensitive information.
I agree to its release unless otherwise specified (please explain).

11. SIGNATURE _____ 12. DATE: _____
Patient/Legal Representative

13. PRINT NAME _____

14. SIGNATURE OF EMPLOYEE RELEASING RECORD _____
(SIGNATURE OF EMPLOYEE MUST BE LEGIBLE!)

15. DATE: _____
(PLEASE VALCO SCAN PHOTO ID, AND SCAN COMPLETED FORM. DO NOT SCAN FORM UNTIL COMPLETE. INDIVIDUALS OTHER THAN THE PATIENT, DIRECT TO MED.RECORDS DEPT.)