SKYLINE HOSPITAL CONSENT FOR RELEASE OF INFORMATION	
Patient Name:	Maiden/Nickname/Other Names:
Address:	Date of Birth:
City/State/Zip:	Phone Number:

Please **OBTAIN** information **FROM**:	Please **SEND/GIVE** written or verbal information **TO**:
Name of Physician:	Person to Receive my Information:
Name of Hospital/Clinic:	Circle Title - Self, Physician, Attorney, Spouse, Family
Address:	Address:
City/State/Zip:	City/State/Zip:

I authorize above named Hospital, Clinic or Physician to release the following protected health information:

____ Specific Treatment Date/s or Admission/s: ____

____ Specific Information as Indicated:

- ☐ X-Ray Film/CD/Reports
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Laboratory Report
- ☐ History & Physical Report
- ☐ Discharge Summary
- ☐ ER Report
- ☐ Financial/Billing Records
- ☐ Other:

I understand that certain information in these records cannot be released without specific authorization because of Federal and/or State law. By **INITIALIZING** below, I specifically authorize the release of the following confidential and protected health information:

____ HIV Test and/or other sexually transmitted disease test results and related information, including documentation of high-risk behavior.
____ Genetic testing results and related information.
____ Drug and/or alcohol diagnosis, treatment and/or referral information.
____ Mental health treatment information.

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My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in this Consent. **This Consent will expire one year from date of signature below.**

______________________________________ Signature of Patient

______________________________________ Signature of Parent or Legal Guardian (if applicable)

Date: ______________________________________

______________________________________ Signature of Witness

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For Office Use Only:

Date Records Sent: ____________________________

Sent via (circle): Mail Fax Picked up

Picked up by: ____________________________

Copy of Release Sent to: __________ on _______

***Fee Schedule/Payment Policy*:** We do not charge for records provided to patients or physicians & hospitals for continuity of patient care.
Timeline: Please allow 14 days for completion of your request for records. Please call us if you choose to pick up your records.
ROI Contact Information: Skyline Hospital Release of Information Clerk: 509-637-2943