GENERAL RELEASE OF MEDICAL INFORMATION

Putnam County Hospital
1542 S. Bloomington Street
Greencastle, IN 46135
Phone (765)- 655-2590
Fax (765)- 655- 2604

PATIENT NAME: _____BIRTHDATE: ____/____/____

PATIENT ADDRESS: _____
CITY: _____STATE: _____ZIP: _____
PHONE: _____

I HEREBY REQUEST AND AUTHORIZE PUTNAM COUNTY HOSPITAL TO RELEASE TO: (Self, physician, or other facility)

_____
(name of person or organization)

_____
(street/mailing address)

_____
(city, state and zip code)

THE FOLLOWING INFORMATION: _____

FROM MEDICAL RECORDS PERTAINING TO MY TREATMENT ON THE FOLLOWING DATES: _____
THE PURPOSE FOR THE RELEASE OF THIS INFORMATION IS:
_____
(personal, insurance, etc)

I UNDERSTAND THAT:

1. Putnam County Hospital is hereby released from all legal responsibility or liability for the release of the records to the extent indicated and authorized herein;
2. This authorization may be revoked in writing at any time BEFORE the release of the above information;
3. This authorization will expire (30) days after the date of my signature; and
4. Putnam County Hospital may charge me or any designated recipients the actual cost of preparing the copies requested.

SIGNED: _____DATE: _____
(patient/other authorized person)
Relationship if other than patient: _____
Date Requested: _____Auth.Received: _____
Date Released: _____ Preparer's Initials: _____
Medical Record #_____ Account #:_____

(We will need a copy of a photo ID card. Picture has to be legible.)

Items given: ___ CD ____ Films ____ Report ____Other: _____