Goshen Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

200 HIGH PARK AVE
GOSHEN, IN 46526
(574)364-2624

Patient's name:_____ **Date of Birth**_____
Patient's address:_____
_____ **Phone #:**_____
City **State** **Zip**
I Hereby Authorize:_____ Goshen Hospital (or)_____
(Name of Medical Facility, Agency, or Other)
To Release to: ____ Myself____ GH (or)_____
(Name of Medical Facility, Agency, or Other)
Address (if Other Authorized Person):_____

The following specific portions or my medical record including information regarding drug abuse and/or alcoholism:

___Face Sheet ___Pathology Reports ___Emergency Dept. Records
___Discharge Summary ___Lab Results ___Day Surgery
___History & Physical ___Radiology/Images ___Other:_____
Date(s) Requested is:_____

The Medical Record is requested for the following purpose:

___Attorney ___Disability
___Insurance ___Personal
___Follow-up/Continued Medical Treatment ___Other:_____

It is understood that this authorization is subject to revocation by me at anytime except the extent that action has been taken to release this information. This authorization should remain valid until revoked and will expire in sixty (60) days, or upon the following event condition:

I further agree to pay, AS NECESSARY, the copying costs for these medical records.

_____
Signature of Patient **Date signed**
(or signature of Other Authorized Person*)

_____
Relationship of Other Authorized Person **Address of Other Authorized Person**

_____

Please Complete if Patient is Deceased;

I certify that no personal representative has been appointed and that I am the _____ of the deceased. **(Relationship)**

_____
Signature of Other Authorized Person **Date Signed**

*Person or legal guardian if patient is under age 18; legal guardian of any patient under guardianship; personal representative of deceased patient (or if not personal representative, the spouse of a deceased patient; or if not spouse, any adult child of a deceased patient).