AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME OF PATIENT: ________________________________ **DATE:**___________

SPECIFIC DATE OF CARE: ______________ **DATE OF BIRTH:**___________

To the Health Information Management Department of:

Irwin County Hospital

710 N. Irwin Avenue, Ocilla, GA 31774

You are hereby authorized to allow: ____
(patient name/doctor/other facility/person receiving information)

to be furnished a copy of the hospital records, including pictures, on the above-named patient. Irwin County Hospital and you personally are hereby released from all legal responsibility or liability for the release of the records, including pictures, to the extent indicated and authorized herein.

___________________________________ _______________

(Signature of patient) (Date of Signature)

___________________________________ _______________

(Signature of nearest kin) (Date of Signature)

____
(Relationship)