GOODALL-WITCHER HOSPITAL
101 South Avenue T
P. O. Box 549
Clifton, Texas 76634
Telephone: 254-675-8322 Fax: 254-675-3279

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

PATIENT NAME:_____

ADDRESS:_____

DATE OF BIRTH:_____ **SOCIAL SECURITY NUMBER:**_____

I authorize _____Goodall-Witcher Hospital_____ to release the following medical information to:

Name of Person/Facility_____

Address:_____

Check all that may be released:

___History & Physical Exam	___Discharge summary	___Progress notes
___Lab Reports	___X-ray reports	___EKG Reports
___Operative Reports	___Consultations	___Therapy Reports
___Pathological Reports	___Emergency Record	___EEG Reports

___Other (Please Specify)_____

This authorization covers patient care given from _____ to _____

Purpose of disclosure: ___Medical Care ___Insurance ___Attorney
___Other_____

This authorization shall be valid for 90 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date. The patient agrees that a photocopy of this authorization may be considered valid.

Date:_____SIGNATURE:_____
Patient or legally authorized representative

If other than patient signs, relationship that constitutes legally authorized representative must be documented_____
Written evidence of a legally authorized representative's status must be presented to the hospital prior to release of any information.