Foothills Medical Group
Olean General Hospital

Release of Medical Information

Patient's Name: _____ Date of Birth ___/___/_____

To be released from:

Name: _____

Address: _____

Phone: (____) ____-_____ Fax: (____) ____-_____

To be released to:

Name: _____

Address: _____

Phone: (____) ____-_____ Fax: (____) ____-_____

Please release the following records:

- ☐ Entire Records
- ☐ Demographics
- ☐ Progress Notes
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Emergency Room Reports
- ☐ Physician's Orders
- ☐ Medication Records

I understand that I can revoke this authorization by providing written notice to the Health Information Department at Olean General Hospital Physician Practices at the address listed above or in a manner described in the Notice of Privacy Practice. I also understand that if information has been released by relying upon this authorization, that revocation will not be valid.
I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or dependency, psychiatric or psychological illness, mental illness or retardation and acquired immune deficiency Syndrome (AIDS).
The Physician's office listed above may not condition treatment or payment on the signing of this authorization unless allowed by law.
I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information.
I understand that this Release of Medical Information will expire one year from the date listed below.
I authorize Olean General Hospital Physician Practices to obtain my previous health records.

_____ ____/____/_____
Patient (parent or guardian) Signature Today's Date