



CLARENDON HEALTH SYSTEM

RESTRICTION AGREEMENT RELEASE OF PATIENT INFORMATION CONSENT FORM

Release Information to: _____

Address: _____

Reason for Release: _____

Please Initial: (only one)

_____ I hereby authorize Clarendon Memorial Hospital to provide the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

_____ I hereby authorize Clarendon Memorial Hospital to provide the above-named individual or company with specific elements of my medical data and information as designated below, concerning my illness or injury.

_____ I hereby refuse Clarendon Memorial Hospital to provide the above-named individual or company with medical data and information concerning my illness or injury.

MEDICAL DATA/INFORMATION

_____ Name, address, phone number

_____ Social Security Number

_____ Date of admission

_____ Admitting diagnosis

_____ Findings of physical examination

_____ Laboratory data

_____ Reports of diagnostic tests

_____ Reports of surgical procedure

_____ Listing of medications

_____ Listing of treatments

_____ Information from physician consults

_____ Ancillary personnel notes (check all those that apply)

- Nursing Social Services Pharmacy Dietary Psychiatric Services

Signature of Patient: _____ Date: _____

Print Name: _____ DOB: _____

Signature of Witness: _____ Date: _____