angels grace
HOSPICE
440 Quadrangle Drive Suite G
Bolingbrook IL 60440
888-444-8341 Phone
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FILL IN

Patient: _____ MR#: _____

DOB: _____ SSN#: _____ Sex: _____

I hereby authorize and request release of information

From: _____ To: _____

_____ _____

_____ _____

The information to be disclosed is:

_____ History and Physical

_____ Laboratory

_____ Consultation

_____ X-rays

_____ Progress Notes

_____ Copy of Out-of-Hospital DNR, if applicable

_____ Discharge Summary

_____ Other _____

The purpose of this disclosure is to best facilitate the care delivered by Angels Grace Hospice. I understand that information containing HIV testing and lab results may be included. Reports may include information on drug, alcohol and psychological treatment.

I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it and that this authorization expires automatically when I am no longer under the care of Hospice.

FILL IN

_____ _____
Signature of Patient/Authorized Person Date

_____ _____
Print Name Relationship to Patient