Jacobson
Memorial Hospital
Care Center & Clinics
Peace of Mind, Close to Home!

601 East Street North, P.O. Box 367
Elgin, ND 58533
Phone 701-584-2792 ❖ Fax 701-584-3348

REQUEST FOR RELEASE OF INFORMATION

It is hereby requested that ______________________________________ release any medical records or medical information regarding my history, physical findings, diagnosis, and treatment to: ______________________________________

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> * This authorization will remain effective for one (1) year and will automatically expire without my express revocation. I understand that I may cancel this request with written notification.

RE: ______________________________
(Name)

____
(Address)

____
(Birthdate)

Signature: X ______________________________ Date: ______________

Witness: X ______________________________ Date: ______________

If signed by person other than patient, specify reason patient is unable to sign: ______________

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Legal Authority:

☐ Legal Guardian ☐ Parent of Minor ☐ Next of Kin ☐ Power of Attorney for Health Care

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Information Released: ________ Mail ________ Fax ________ Hand Carry

________ Summary Sheet (Face Sheet)
________ Emergency Room – Outpatient Record
________ Discharge Summary
________ History and Physical Exam
________ Progress Notes
________ Physician's Orders

________ EKG Tracings
________ X-Ray Reports
________ Laboratory Reports
________ Nurses Notes
Other ______________________
____

From date(s) of service: ______________________

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Released by: ______________________________ Date: ______________