RELEASE OF MEDICAL INFORMATION
REQUEST/AUTHORIZATION FORM

PATIENT NAME ____________________ PATIENT NO ____ DATE OF BIRTH _____CONTACT_____

I authorize Ladnan Hospital to release information to

Name of person or organization ____

The release of the medical information will be done via

- ☐ Mail
- ☐ Person
- ☐ E- mail
- ☐ Other (Please specify) ____

Date of visit to Ladnan Hospital _______________ Doctor's Name _______________________

Type of information to be disclosed

- ☐ Laboratory Reports
- ☐ Radiology Reports (X-ray, Ultra sound, CT, MRI reports)
- ☐ Discharge summary
- ☐ Others (Please Specify) ____

Reason for Request

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I understand that I may revoke this authorization at any time by written notification to Ladnan Hospital following this date, except for the information, which may have been released prior to the revocation.

Name and Sign ____________________________________ Date _____________
Patient or person giving consent

Signature _______________________

Received by (Name)_________________________________ Date __________________
Ladnan Hospital