CULLMAN REGIONAL

Patient #: _____ Room #: _____ MR #: _____

Patient Name: _____

DOB: _____ Age: ____ Sex: __ Date: _____

Authorization to Release Limited Health Information to Specified Individuals

Cullman Regional is dedicated to protecting patient privacy. It is your right to receive quality care without concern that your personal health information will be shared or disclosed to others without your authorization. Your medical information is protected by law and will **ONLY** be used in treatment, payment, and healthcare operation services.

This is to authorize Cullman Regional and staff to release limited medical information to your designated family members, significant others or friends **regarding your presence, room/location and medical condition, if known, during your stay.** I understand this authorization is not valid after discharge and does not allow release of my medical records.

Please list authorized family members, significant others or friends we can call or release information to regarding your stay.

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

This is to authorize Cullman Regional to release information to your designated family members or significant others **regarding your bill.**

Please list authorized family members, significant others or friends we can call or release information to regarding your bill:

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

Name: _____ **Phone #:** _____

If there is no one listed, we can ONLY talk to you regarding your bill.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____