TRENTON MEDICAL CENTER, INC.

Trenton Medical Center
911 South Main Street
P.O. Box 640
Trenton, FL 32693
Phone: (352) 463-2374
Fax: (352) 463-2726

Bell Family HealthCare
1830 North Main Street
P.O. Box 639
Bell, FL 32619
Phone: (352) 463-1100
Fax: (352) 463-3924

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM
Trenton Medical Center, Inc.

PATIENT'S NAME: _____
SS#: _____ DOB: _____

I authorize Trenton Medical Center, Inc., to furnish any and all medical records in its possession regarding the above named patient. I specifically consent to the release of any information contained in the medical record which may relate to psychiatric illness and treatment; results of Human Immunodeficiency Virus (HIV) testing, or treatment of AIDS related illnesses; STD's; TB; Adult and/or Child Abuse; Drug or Alcohol Abuse or treatment. Any restrictions on this authorization are listed below: _____

_____

_____

Please release my records to (Must have complete Name and Address of Facility we will be sending your records):

_____

_____

I hereby release Trenton Medical Center, Inc., the employee's and associated health care providers from any liability that may arise from the release of information as I have directed. Furthermore, I understand that you have no responsibility for the use of this information by the party to whom it is released. I authorize you to transmit this information by fax, and release you from any liability for breach of confidentiality, misdirection or transmission, or failure to receive transmission if my records are transmitted by fax.

I understand that this authorization will remain in effect for the next twelve (12) months. Unless revoked in writing.

Signature: _____ Date: _____
If signed by other than patient, relationship to patient: _____

Witness Signature: _____ Date: _____