NANTUCKET
COTTAGE HOSPITAL

Sensitive Information

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL INFORMATION

I, _____ _____
(*Patient Name – please print*) *Date of Birth*

_____
Current Address

_____ _____
Zip Code *Telephone # & Area Code*

Hereby authorizes Nantucket Cottage Hospital to disclose to:

_____
(*Name of person or agency to receive information*)

_____
Address *Zip Code*

the following specific information:

_____

_____

_____

for the period of _____through _____(list dates)

The above information is to be released for the following purpose only. Any other use or re-disclosure is forbidden. **PURPOSE:**

_____

_____

_____

I understand that my records are protected under the Federal and State Confidentiality legislation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. In any event, this authorization will automatically expire upon completion of this request not to exceed 30 days after the date below. I understand that I must provide a picture ID when picking up record copies.

I further acknowledge that the information to be released and the implications thereof are fully understood by me and this consent is given of my own free will.

Signature: _____ Date:_____

Witness: _____ Date:_____