General Release of Medical Information

Patient Name

Patient Date of Birth

Address

City

State

Zip

Phone Number

I hereby authorize

to release to:

Greene County General Hospital / My Clinics
1185 North 1000 West
Linton, IN 47441

Phone: (812) 847-4481
Fax: (844) 658-7526

The following information:

From Medical Records pertaining to my treatment on the following dates:

For the following purposes:

- ☐ Personal
- ☐ Insurance
- ☐ Continuing Care
- ☐ Other

I understand that:
Greene County General Hospital is hereby released from all legal responsibility or liability for the release of the records to the extent indicated and authorized herein;
This authorization may be revoked in writing at any time BEFORE the release of the above information;
This authorization will expire (60) days after the date of my signature; and
Greene County General Hospital may charge me or any designated recipients the actual cost of preparing the copies requested.

Signature of patient or Legal Guardian

Relationship if other than Patient

Name if other than Patient

Date Requested

Date Released

Authorization Received

Preparer's Initials

Medical Record Number

Account Number

Completed form can be dropped of at any My Clinic location, faxed to 812.846.3311, or emailed to My.Clinics@mygcgh.org.