Catahoula Parish Hospital District #2

Self-Release of Records

I, ______________________________, hereby authorize Catahoula Parish Hospital District #2 to release photo copies of my records into my own keeping, and/or allow myself to review my chart. I further release Catahoula Parish Hospital District #2 from responsibility for any deleterious effect that the review of my medical records may have upon myself or others, both now and in the future. I personally accept all responsibility for my own interpretation of the medical information contained therein, and hold blameless Catahoula Parish Hospital District #2 for conclusions or opinions drawn from said records. I realize from the receipts of these records that I am accepting responsibility for protection of my own right of previous confidentiality.

Patient Signature: _________________________ Date: ___/____/_____

Witness: __________________________ Date: ___/____/_____

Comments:

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