AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: ____ ________Phone Number: _______________________

Other Names Used: ______________________ Date of Birth: _____/_____/______ Social Security Number: xxx-______-_________

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named individual

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

Continuing Medical Care	Military	Personal Use	School	Insurance
Legal Purposes	Social Security/Disability	Other		

DATE (S) OF TREATMENT: ____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Pathology Reports	Radiology Reports	Discharge Instructions
Behavioral	Radiology Images	Other:

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED

Paper	Electronic Media (requires 2 business days)	Fax to Healthcare office

METHOD OF DELIVERY

Pick Up (you will be notified via a telephone call when your records are ready	Mail (please provide address below)

PHONE NUMBER: ________________________________ NAME OF INDIVIDUAL RECEIVING RECORDS: ____________________________________

____(**May release the above information to)**
Hospital/Healthcare Facility Name

____
Address (Street, City, State, Zip code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I understand I may be charged a fee for copies of my medical records according to Texas Hospital Licensing Law. Please see a Health Information Management employee for pricing information.

This authorization will expire 180 days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows: ____.

Date: ____________________________ Signature: ____
Patient or Legally Authorized Representative

Printed Name: ___________________________________ Relationship to Patient: ____

MRN: VERIFY PATIENT IDENTIFICATION AND/OR LEGAL GUARDIANSHIP