Authorization for Release of Information

Name of Patient: _____ Date(s) of Service: _____

Date of Birth: _____ Social Security Number: _____

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

PATIENT INFORMATION IS NEEDED FOR:

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

INFORMATION TO BE RELEASED OR ACCESSED:

❒ History & Physical ❒ Consultation Report(s) ❒ Emergency Room Record
❒ Operative Reports ❒ Discharge / Death Summary ❒ Face Sheet
❒ Lab / Pathology Reports ❒ X-ray Reports/ Images ❒ Other: _____

_____ (Hospital Name) may release the above information to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):

_____
(Individual or Organization Name) (Phone Number)

_____
(Address: Street, City, State and 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 redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, 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 the authorization. I understand I may be changed a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (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:

_____

❒ When checked, I understand the record is incomplete and additional documentation will be added. I understand that I may request a complete copy at approximately 30 days post discharge. I understand I may be charged for both copies of the medical record.

Signature: _____ Date: _____
Patient or legally Authorized Representation

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient