SCOTT&WHITE Healthcare

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Scott & White Healthcare to release the information indicated from the medical record of:

Patient Name	Date of Birth	Medical Record Number
Street Address	City, State Zip	Telephone Number

Please release this information to:

Individual/Organization Name		Telephone Number
Street Address	City, State Zip	Fax Number

I understand there is a charge for photocopies, as permitted by Texas law, unless copies are sent directly to another healthcare provider. □ I would like to review my record.

Please release information from these hospitals or clinics: _____

Please release the following information for these treatment dates: _____

Include this information (if applicable): □ Alcohol/Drug □ Genetics □ HIV/AIDS □ Mental Health

Purpose: □ Attorney/Legal	**Purpose: □ Continued Care**	**Purpose: □ Insurance**	**Purpose: □ Personal Use**
□ Complete record □ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) □ EKG/EEG/EMG reports □ Immunization records □ Laboratory reports □ Medication records □ Nursing notes □ Physician orders □ Progress notes □ Radiology reports □ Other: _____ _____ _____	□ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) □ EKG/EEG/EMG reports □ Immunization records □ Laboratory reports □ Radiology reports □ Other: _____ _____ _____ _____ _____ _____ _____ _____	□ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) □ EKG/EEG/EMG reports □ Immunization records □ Laboratory reports □ Radiology reports □ Other: _____ _____ _____ _____ _____ _____ _____ _____	□ Complete record □ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) □ Billing records □ EKG/EEG/EMG reports □ Immunization records □ Laboratory reports □ Medication records □ Nursing notes □ Physician orders □ Progress notes □ Radiology reports □ Radiology images □ Other: _____

I understand the following:

- I am not required to sign this authorization to obtain treatment at Scott & White.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization in writing at any time except to the extent Scott & White has already relied on this authorization. To revoke my authorization, I will provide a written request to the Health Information Management Department.
- My record may contain information that only a physician can interpret. I will contact my physician if I have questions about my diagnosis or treatment. I will not hold Scott & White liable for any misinterpretation of information if I fail to contact my physician for clarification.

This authorization will expire in 180 days or at the date or event specified here: _____

Signature of Patient or Legal Representative	Printed Name of Patient or Legal Representative	Date
	Representative's Authority to Act for Patient	