

### AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

I, the undersigned, authorize the release of or request access to the information specified below from \_\_\_\_\_  
Physician's Name

Address  
Of the above-named patient's medical record(s).

PATIENT INFORMATION IS NEEDED FOR:

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Military     | <input type="checkbox"/> Social Security Disability |
| <input type="checkbox"/> Insurance               | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Legal Purposes          | <input type="checkbox"/> School       | _____   |

INFORMATION TO BE RELEASED OR ACCESSED:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Reports   | <input type="checkbox"/> X-ray Reports/Images  |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Lab/Pathology       | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Care Plan          | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Face Sheet            |
| <input type="checkbox"/> EKG Reports        | <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Other _____           |

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

\_\_\_\_\_  
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

\_\_\_\_\_  
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 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 charged 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:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Patient or Legally Authorized Representative

\_\_\_\_\_  
Printed Name of Patient or Legally Authorized Representative

\_\_\_\_\_  
For department use: MRN/Acct #

\_\_\_\_\_  
Relationship to Patient