

## 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 the medical record(s) of the above-named patient.

**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"/> Consultation Report     | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Operative Reports     | <input type="checkbox"/> Discharge/Death Summary | <input type="checkbox"/> Face Sheet            |
| <input type="checkbox"/> Lab/Pathology Reports | <input type="checkbox"/> Radiology Reports       | <input type="checkbox"/> Other: _____          |
|  | <input type="checkbox"/> Radiology Images        |  |

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

\_\_\_\_\_  
(Individual or Organization Name) 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 departmental use: MRN/Acct# \_\_\_\_\_

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



**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

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PATIENT IDENTIFICATION

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Texas Health Arlington Memorial Hospital                        | <input type="checkbox"/> Texas Health Harris Methodist Hospital Stephenville | ┌ |
| <input type="checkbox"/> Texas Health Harris Methodist Hospital Azle                     | <input type="checkbox"/> Texas Health Presbyterian Hospital Allen            |   |
| <input type="checkbox"/> Texas Health Harris Methodist Hospital Cleburne                 | <input type="checkbox"/> Texas Health Presbyterian Hospital Dallas           |   |
| <input type="checkbox"/> Texas Health Harris Methodist Hospital Fort Worth               | <input type="checkbox"/> Texas Health Presbyterian Hospital Kaufman          |   |
| <input type="checkbox"/> Texas Health Harris Methodist Hospital Hurst - Euless - Bedford | <input type="checkbox"/> Texas Health Presbyterian Hospital Plano            |   |
| <input type="checkbox"/> Texas Health Harris Methodist Hospital Southwest Fort Worth     | <input type="checkbox"/> Texas Health Presbyterian Hospital Winnsboro        |   |
|  | <input type="checkbox"/> Other _____   | └ |



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**AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN DEL PACIENTE**

Nombre del Paciente: \_\_\_\_\_ Fecha(s) del Servicio \_\_\_\_\_

Fecha de Nacimiento \_\_\_\_\_ Número de Seguridad Social \_\_\_\_\_

Yo, el que firma abajo, autorizo la divulgación o la solicitud de acceso a la información que se indica a continuación del expediente(s) médico del paciente nombrado arriba.

**LA INFORMACIÓN DEL PACIENTE SE NECESITA PARA:**

- Continuación de Cuidados Médicos
- Seguro
- A efectos legales
- Militar
- Uso Personal
- Colegio
- Seguridad Social/Incapacidad
- Otro: \_\_\_\_\_

**INFORMACIÓN PARA SER DIVULGADA O TENER ACCESO:**

- Historial y Físico
- Reportes Quirúrgicos
- Reportes de Laboratorio/Patología
- Reporte de Consulta
- Dada de Alta/Fallecimiento
- Reportes de Radiología
- Imágenes de Radiología
- Récord de Sala de Emergencia
- Cubierta de informes
- Otro \_\_\_\_\_

\_\_\_\_\_  
(Nombre del Hospital) puede divulgar la información anteriormente mencionada a (indique el nombre o título del individuo o el nombre de la organización a quien se divulgarán los reportes y la dirección apropiada)

\_\_\_\_\_  
(Nombre del Individuo o de la Organización) Teléfono \_\_\_\_\_

\_\_\_\_\_  
Dirección (Calle, Ciudad, Estado, Código Postal)

Entiendo que mis expedientes son confidenciales y no pueden ser divulgados sin mi autorización por escrito, excepto cuando de otra manera sea permitido por ley. La información usada o divulgada por esta autorización puede ser divulgada de nuevo por el que la recibe y no quedar protegida. Entiendo que la información indicada para ser divulgada puede incluir pero no se limita a: historial, diagnósticos y/o tratamiento de abuso de drogas o alcohol, enfermedad mental o enfermedad contagiosa, incluyendo el Virus de Inmunodeficiencia Humana (VIH) y el Síndrome de Inmunodeficiencia Adquirida (SIDA).

Entiendo que el tratamiento o pago no está condicionado a la firma de esta autorización, excepto en determinadas circunstancias como la de participación en programas de investigación, o la autorización de la divulgación de los resultados de pruebas con anterioridad a un empleo. Entiendo que puedo revocar esta autorización por escrito en cualquier momento excepto la información que ya se haya divulgado en base a esta autorización. Entiendo que se puede cobrar un cargo de búsqueda/procesamiento y por copias de mi expediente médico de acuerdo a la Ley de Certificación de Hospitales de Texas.

Esta autorización vencerá ciento ochenta (180) días después de la fecha de mi firma a no ser que revoque la autorización antes de ese tiempo o a no ser que se indique de otra manera por fecha, evento o condición como se indica aquí:

Fecha \_\_\_\_\_ Firma: \_\_\_\_\_  
Paciente o Representante Legalmente Autorizado

\_\_\_\_\_  
Nombre en letra de imprenta del Paciente o Representante Legalmente Autorizado

\_\_\_\_\_  
Para uso del departamento Relación con el Paciente



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**AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN DEL PACIENTE (Spanish)**

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PATIENT IDENTIFICATION

- Texas Health Arlington Memorial Hospital
- Texas Health Harris Methodist Hospital Azle
- Texas Health Harris Methodist Hospital Cleburne
- Texas Health Harris Methodist Hospital Fort Worth
- Texas Health Harris Methodist Hospital Hurst - Euless - Bedford
- Texas Health Harris Methodist Hospital Southwest Fort Worth
- Texas Health Harris Methodist Hospital Stephenville
- Texas Health Presbyterian Hospital Allen
- Texas Health Presbyterian Hospital Dallas
- Texas Health Presbyterian Hospital Kaufman
- Texas Health Presbyterian Hospital Plano
- Texas Health Presbyterian Hospital Winnsboro
- Other \_\_\_\_\_

# Addresses and Phone Numbers

Please mail the requested documentation to the relevant hospital address, listed below. Note that individuals requesting medical records must present a government-issued photo ID at the time of pickup.

**Texas Health Arlington Memorial Hospital**  
Health Information Management Department  
800 West Randol Mill  
Arlington, TX 76012  
817-960-6250

**Texas Health Specialty Hospital Fort Worth**  
Health Information Services Department  
1301 Pennsylvania Avenue  
Fort Worth, TX 76104  
817-250-3580

**Texas Health Harris Methodist Hospital Azle**  
Health Information Services Department  
108 Denver Trail  
Azle, TX 76020  
817-444-8644

**Texas Health Presbyterian Hospital Allen**  
Health Information Services Department  
1105 Central Expressway  
Suite 100  
Allen, TX 75013  
972-747-1000

**Texas Health Harris Methodist Hospital Cleburne**  
Health Information Services Department  
201 Walls Drive  
Cleburne, TX 76031  
817-556-4281

**Texas Health Presbyterian Hospital Dallas**  
Health Information Services Department  
8200 Walnut Hill Lane  
Dallas, TX 75231-4402  
214-345-7670

**Texas Health Harris Methodist Hospital Fort Worth**  
Health Information Services Department  
1301 Pennsylvania Avenue  
Fort Worth, TX 76104  
817-250-3580

**Texas Health Presbyterian Hospital Kaufman**  
Health Information Services Department  
850 Highway 243 West  
Kaufman, TX 75142  
972-932-7292

**Texas Health Harris Methodist Hospital Hurst-Euless Bedford**  
Health Information Services Department  
1600 Hospital Parkway  
Bedford, TX 76022  
817-848-4079

**Texas Health Presbyterian Hospital Plano**  
Health Information Services Department  
6200 West Parker Rd.  
Plano, TX 75093-7914  
972-981-8168

**Texas Health Harris Methodist Hospital Southwest Fort Worth**  
Health Information Services Department  
6100 Harris Parkway  
Fort Worth, TX 76132  
817-433-6200

**Texas Health Presbyterian Hospital Winnsboro**  
Health Information Services Department  
719 West Coke Rd.  
Winnsboro, TX 75494-3098  
903-342-4134

**Texas Health Harris Methodist Hospital Stephenville**  
Health Information Services Department  
411 North Belknap  
Stephenville, TX 76401  
254-965-1538