

**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 patient.

**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 Health     Radiology Images     Other \_\_\_\_\_

**FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:**

- Paper     Electronic media\* (requires 2 business days)     Release to MyCare account\* (\*only applies to data stored electronically)

**METHOD OF DELIVERY:**

- Pick Up (You will be notified via a telephone call when records are ready for pick up)
- Mail to Address listed below

**May release the above information to:**

\_\_\_\_\_  
(Hospital Name)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
Address (Street, State, Zip Code)

\_\_\_\_\_  
Phone Number

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, 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

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PATIENT IDENTIFICATION

Texas Health \_\_\_\_\_



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