AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION FORM PLEASE, FILL OUT ENTIRE FORM TO BE VALID UNDER HIPAA LAWS.

Patient Name:	Date of Birth:	MR#
Address:	Phone #:	SS#
City:	State:	Zip Code:
<u>To be completed by requester</u> : □Pick up	o □Mail □Other:	
If requested health information is needed	for a doctor's appointment please specify d	late:
RECORDS CAN ONLY BE FAXED T	O ANOTHER HEALTHCARE PROVI	DER.
Name: Texas Health Huguley Hospital F	on is authorized to make the following di Fort Worth SouthAddress:11801 Sou State:TX	th Freeway
Admission/Discharge Date: Forward to Health Information Manag	romant (Madical Bacanda) fam	
□ Abstract □ Discharge Summary	 Operative Report Emergence Laboratory Report Radiology 	cy Room Report y Report
Forward to Radiology Dept for: \[X-r		ardiology Dept for: Cath Lab Films tive notes, emergency record, lab, radiology, physical
Reason for requesting information: Request may be subject to copying fee.		
	nd used by the following individual or or	
Address:		
City:	State:	Zıp:
present my written revocation to the Health In has already been released in response to this provides my insurer with the right to contest date event or condition (not to exceed 18 authorization will expire 180 days from the	nformation Management Department. I understa authorization. I understand that the revocation a claim under my policy. Unless, otherwise re 0 days): If I fail to a date signed.	f I revoke this authorization I must do so in writing and and that the revocation will not apply to information that will not apply to my insurance company when the law evoked, this authorization will expire on the following o specify an expiration date, event or condition, this
order to assure treatment. I understand that I understand that any disclosure of information	may inspect or obtain a copy of the information carries with it the potential for an unauthorized	se to sign this authorization. I need not sign this form in n to be used or disclosed, as provided in CFR 164.524. I d re-disclosure and the information may not be protected n, I can contact the authorized individual or organization
		l or drug abuse/testing information which may be rd may include information relating to AIDS, HIV,
Patient Signature:		Date:
Authorized Representative/Parent:		Date:
Printed Name of Authorized Representation	ive/Parent:	
Relationship to Patient:	esentative/Parent:	
Address and Fhole # Of Address Repl		
Return this completed form along v Mail to: Attention: Health Informati	with a copy of photo ID to the USPS a on Management	address or fax below

Texas Health Huguley Fort Worth South PO Box 6337 Fort Worth, TX 76115 Send FAX to 817-551-2447 DI

DIRECT PHONE 817-551-2741