AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ **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: Any and All

INFORMATION TO BE RELEASED OR ACCESSED:

☑ History & Physical ☑ Discharge/Death Summary ☐ Discharge Instructions
☑ Operative/Procedure Reports ☑ Radiology Reports ☑ Clinic Notes
☑ Lab/Pathology Reports ☐ Radiology Images ☐ Immunizations
☐ Behavioral Health ☑ Emergency Room Record ☑ Other: EKG Tracings
☑ Consultation Report ☑ Face Sheet

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

☐ Paper ☑ Electronic Media : To Fax Number(214) 345-7105

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via a telephone call when records are ready.)
☐ Mail to Address Listed Below ☐ Release to MyChart Account
☑ Email to: IEEMOutpatient Clinic @ texashealth.org **Choose one:** ☐ Encrypted ☐ Unencrypted

The health information will be sent by encrypted email unless I specify otherwise. By requesting unencrypted email, I acknowledge that there is some risk that health information could be accessed by a third party.

_____
Facility Name

May release the above information to:

Texas Health Presbyterian Hospital - Dr. Benjamin Levine
Name

7232 Greenville Avenue, Ste 339, Dallas, TX 75231 | Phone: (214) 345-4626 | Fax: (214) 345-7105)
Address (Street, City, 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: _____

_____
Signature of Patient or Legally Authorized Representative Printed Name | Printed Name of Patient or Legally Authorized Representative | Date

_____ _____
For Department Use: MRN/Acct # | Relationship to Patient

FACILITY NAME MUST BE FILLED IN BLANK BELOW

ROI

Texas Health®

PATIENT IDENTIFICATION