AUTHORIZATON FOR HEALTH CARE INFORMATON DATA EXCHANGE

Name of Patient_____ Date of Birth _____

Address _____

I, the undersigned, authorize the release of information described below from medical record(s) of the above-named patient.

PATIENT INFORMATION IS TO BE USED FOR: Continuing medical care

INORMATION TO BE RELEASED OR ACCESSED: Complete record of treatment, to include for example: medical history, allergies, transcribed reports, and test results

Texas Health hospitals and Texas Health Physicians Group may use or release the above information from the following health information exchanges:

Any health care providers using Epic electronic medical record | various locations (including all Texas Health Facilities listed below), and
SANDLOT, LLC | 1701 River Run, Suite 210 | Fort Worth, Texas 76107

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. 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. The revocation request may be submitted to the health information management of this hospital or doctor's office (medical records) for processing.

Obstetric patients only: This authorization is also given for any child(ren) born to me during hospitalization.

This authorization will remain in effect, indefinitely, unless I revoke the authorization.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Legally Authorized Representative Date

TO DECLINE, COMPLETE THIS SECTION:

The above named patient declines to participate in the Health Care Information Data Exchange.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

A "legally authorized representative" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of clergy. NOTE: Written evidence of legally authorized representative status must be presented to clinic prior to release of any information.

TEXAS HEALTH RESOURCES
AUTHORIZATON FOR HEALTH CARE INFORMATON DATA EXCHANGE
(10/09)

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 Harris Presbyterian Hospital Allen
Texas Health Harris Presbyterian Hospital Dallas
Texas Health Harris Presbyterian Hospital Denton
Texas Health Harris Presbyterian Hospital Kaufman
Texas Health Harris Presbyterian Hospital Plano
Texas Health Harris Presbyterian Hospital Winnsboro
Texas Health Physicians Group