

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Scott & White Healthcare to release the information indicated from the medical record of:

Patient Name	Date of Birth	Medical Record Number
Street Address	City, State Zip	Telephone Number

Please release this information to:

Individual/Organization Name	Telephone Number
Street Address	City, State Zip Fax Number

I understand there is a charge for photocopies, as permitted by Texas law, unless copies are sent directly to another healthcare provider.  I would like to review my record.

Please release information from these hospitals or clinics: \_\_\_\_\_

Please release the following information for these treatment dates: \_\_\_\_\_

Include this information (if applicable):  Alcohol/Drug     Genetics     HIV/AIDS     Mental Health

<b>Purpose: <input type="checkbox"/> Attorney/Legal</b> <input type="checkbox"/> Complete record <input type="checkbox"/> Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) <input type="checkbox"/> EKG/EEG/EMG reports <input type="checkbox"/> Immunization records <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Medication records <input type="checkbox"/> Nursing notes <input type="checkbox"/> Physician orders <input type="checkbox"/> Progress notes <input type="checkbox"/> Radiology reports <input type="checkbox"/> Other: _____ _____ _____	<b>Purpose: <input type="checkbox"/> Continued Care</b> <input type="checkbox"/> Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) <input type="checkbox"/> EKG/EEG/EMG reports <input type="checkbox"/> Immunization records <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Radiology reports <input type="checkbox"/> Other: _____ _____ _____ _____ _____	<b>Purpose: <input type="checkbox"/> Insurance</b> <input type="checkbox"/> Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) <input type="checkbox"/> EKG/EEG/EMG reports <input type="checkbox"/> Immunization records <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Radiology reports <input type="checkbox"/> Other: _____ _____ _____ _____ _____	<b>Purpose: <input type="checkbox"/> Personal Use</b> <input type="checkbox"/> Complete record <input type="checkbox"/> Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) <input type="checkbox"/> Billing records <input type="checkbox"/> EKG/EEG/EMG reports <input type="checkbox"/> Immunization records <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Medication records <input type="checkbox"/> Nursing notes <input type="checkbox"/> Physician orders <input type="checkbox"/> Progress notes <input type="checkbox"/> Radiology reports <input type="checkbox"/> Radiology images <input type="checkbox"/> Other: _____ _____
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I understand the following:

- I am not required to sign this authorization to obtain treatment at Scott & White.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization in writing at any time except to the extent Scott & White has already relied on this authorization. To revoke my authorization, I will provide a written request to the Health Information Management Department.
- My record may contain information that only a physician can interpret. I will contact my physician if I have questions about my diagnosis or treatment. I will not hold Scott & White liable for any misinterpretation of information if I fail to contact my physician for clarification.

This authorization will expire in 180 days or at the date or event specified here: \_\_\_\_\_

Signature of Patient or Legal Representative	Printed Name of Patient or Legal Representative	Date
	Representative's Authority to Act for Patient	