



SCOTT & WHITE
Authorization for Release of Medical Information

MRN: _____
 Date of Doctor's Appointment: _____

I hereby authorize the following information to be released from the medical record of:

Patient Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone #: (____) _____ SS #: _____ (Optional) Treatment Date: _____

This information is to be released:

TO: _____ **FROM:** _____

 City State Zip City State Zip

PLEASE CHECK INFORMATION REQUIRED TO BE RELEASED

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Mammogram Reports | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Mammogram Film | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Lab Report | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> EKG, EEG, EMG | <input type="checkbox"/> Directive to Physician |
| <input type="checkbox"/> X-Ray Report | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Review Medical Record Only |
| <input type="checkbox"/> X-Ray Film | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Other (specify) _____ |

Including information (if applicable) pertaining to:

Psychiatry/Psychology Drug Alcohol HIV/AIDS Genetic Testing

Purpose of Disclosure: Attorney/Legal Continued Patient Care Personal Use (at the request of the individual)
 Commercial Insurance Worker's Compensation Other (specify) _____

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that Scott & White has already relied on this authorization. I understand that I may revoke this authorization by providing Scott & White Release of Information Department a written request for revocation stating my intent to revoke this authorization.

I understand that Scott & White may not condition treatment on my completion of this authorization form.

If information is being released directly to me, I understand that my medical record may contain reports, tests results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Scott & White liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

This authorization will expire in 180 days, or at the date or event specified here: _____.

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

 Signature of Patient or Legal Representative

 Date

 Representative's authority to Act for Patient

 Witness