



# 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: \_\_\_\_\_ SS#: \_\_\_\_\_

Full Address: \_\_\_\_\_

**This information is to be released:** Patient Telephone #: \_\_\_\_\_

**TO:** \_\_\_\_\_ **FROM:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

### PLEASE CHECK INFORMATION TO BE RELEASED

**Treatment Date:** \_\_\_\_\_

**Hospital records:**

- Progress Notes
- Nursing Notes
- Discharge Planning
- Medication Records
- History and Physical
- Discharge Summary

**Clinic records:**

- Clinic Notes
- Ophthalmology
- Dentistry
- Emergency Room

**Other records:**

- Lab Report
- EKG, EEG, EMG
- X-Ray Report
- X-Ray Film
- Mammogram Report
- Mammogram Film
- Other \_\_\_\_\_
- Operative Report
- Pathology Report
- Immunization Record
- Billing Record
- Directive to Physician
- Physician Orders

**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     Review Medical Record Only

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