

Authorization of Release of Patient Information



* D T O O 7 2 *

Consent To Release/Obtain PHI

Patient Name: _____ Phone Number: _____

Other Names Used: _____ Date of Birth: _____ Social Security Number: XXX-_____-_____-_____

Date(s) of Treatment: _____

I, the undersigned, authorize the release of or request access to the information 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: _____

INFORMATION TO BE RELEASED OR ACCESSED:

- | | | |
|---|--|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Discharge/Death Summary | <input type="checkbox"/> Face Sheet |
| <input type="checkbox"/> Lab/Pathology Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> EKG | |

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

- Paper CD (requires 5 business days, only applies to data stored electronically)

METHOD OF DELIVERY:

- Pick Up (You will be notified via telephone call when records are ready for pick up)
 Mail to Address listed below Fax to number listed below Mail to Alternative Confidential Address below

REVOKE PRIOR AUTHORIZATION:

- I hereby revoke all previous authorization for disclosure to _____ to be effective this _____ day of _____, 20_____.

JPS Health Network / Acclaim may release the above information to:

Name _____ Phone Number _____

Address (Street, City, State, Zip Code) _____ Fax Number _____

I understand that the records and disclosed pursuant to this authorization form may include information related to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

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 Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that JPS Health Network has already relied on this authorization. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires 180 days from the date of signature. I understand that JPS Health Network may not condition treatment on my completion of this authorization form.

Signature: _____
Patient or Legally Authorized Representative

For Department Use: MRN / CSN

Printed Name of Patient or Legally Authorized Representative