

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name \_\_\_\_\_ / \_\_\_\_\_ Phone No. \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Maiden/Previous Name)

I, the undersigned, do authorize and request that \_\_\_\_\_  
(Name of Health Care Provider)  
release to \_\_\_\_\_  
(third party payer, other person, or organization)

\_\_\_\_\_ (city, state, zip)  
information from my medical records for the care and treatment that I received on: \_\_\_\_\_  
(Date(s) of Service)

- |  |   |
|--|---|
| <input type="checkbox"/> *Drug or Alcohol Abuse        | <input type="checkbox"/> Acute Hospital Care          |
| <input type="checkbox"/> *Mental Health Treatment      | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> *HIV/AIDS-related Information |   |

\*I understand that the confidentiality of these records will be protected in compliance with state and/or federal law. No information will be released without my written consent unless disclosure is permitted by a court order, or to medical personnel in a medical emergency or for research/monitoring programs. In the case of mental health treatment, this authorization does not change my involuntary/voluntary legal status, but permits release to the insurer. Without this release, I will be personally responsible if the county declines payment.

**Purpose: Mark the appropriate box with an "X" to indicate the reason the record is being requested:**

Continuing Care  Attorney  Personal  Workman Comp  At request of the individual   
Other  (specify) \_\_\_\_\_

The following may be released:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Discharge summary    | <input type="checkbox"/> Emergency Room Report         | <input type="checkbox"/> Lab reports       | <input type="checkbox"/> Dismissal Instructions |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Anesthesia Record             | <input type="checkbox"/> Radiology reports | <input type="checkbox"/> Social History         |
| <input type="checkbox"/> Consultations        | <input type="checkbox"/> Doctors Orders/Progress Notes | <input type="checkbox"/> EKGs              | <input type="checkbox"/> Rehab Therapy Notes    |
| <input type="checkbox"/> Operative Report     | <input type="checkbox"/> Pathology Report              | <input type="checkbox"/> Nurses Notes      | <input type="checkbox"/> Nursing Flow Sheets    |
| <input type="checkbox"/> Delivery Record      |  |  | <input type="checkbox"/> Entire Record          |

Other \_\_\_\_\_

This authorization is effective until \_\_\_\_\_ or for 180 days from the date on which it is signed, whichever is longer. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health Information Management of the releasing health care provider. If authorizing disclosure of mental health records, I understand that I have the right to inspect the information to be disclosed upon proper notification and under appropriate conditions established by the releasing health care provider. Methodist Hospital System and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by State law for mental health records and AIDS-related information, federal requirements (42 C.F.R. Part 2) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes.

I acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
(Signature of Patient or Patient's Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Relationship of Authorized Representative