TRUSTED ER

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient:____**Phone Number**: (_____) ___________________

Other Names Used:______________________________**Date of Birth**:____________________**SSN**: XXX -_______-________

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

DATE (S) OF TREATMENT:____________________________**METHOD OF DELIVERY:** ☐ Pick Up ☐ Mail ☐ Fax

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical ☐ Consultation Report ☐ Emergency Room Record ☐ Operative Reports

☐ Face Sheet ☐ Radiology Reports ☐ Radiology Images ☐ Lab/Pathology Reports

☐ Discharge Instructions ☐ Discharge/Death Summary ☐ Other: _____________

____(______)________________(______)______________________

Hospital Name/Physician Name/Self Phone Number Fax Number

May release the above information to: ____

____(_____)_________________(______)_____________________

Address (Street, State, Zip Code) Phone Number Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: ____

Date:___________________________ **Signature**: ____

Patient or Legally Authorized Representative

MRN/Account #: ______________________

For Department Use

PATIENT ID LABEL

____

Printed Name of Patient or Legally Authorized Representative

____

Relationship to Patient