

AUTHORITY TO REVIEW AND/OR RELEASE PROTECTED HEALTH INFORMATION

AUTHORITY IS HEREBY GRANTED TO _____
 FACILITY

AT _____
 Address City State Zip

TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME, SPECIFICALLY:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> FACE SHEET | <input type="checkbox"/> BILLING RECORDS | <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> DISCHARGE SUMMARY |
| <input type="checkbox"/> DOCTOR'S ORDERS | <input type="checkbox"/> OPERATIVE REPORT | <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> CONSULTATION REPORT |
| <input type="checkbox"/> LAB REPORTS | <input type="checkbox"/> X-RAY REPORT/FILMS | <input type="checkbox"/> CARDIOPULMONARY REPORTS | <input type="checkbox"/> PATHOLOGY REPORTS |
| <input type="checkbox"/> ER REPORTS | <input type="checkbox"/> EMS RECORD | <input type="checkbox"/> MEDICATION RECORDS | |
| <input type="checkbox"/> ENTIRE RECORD | <input type="checkbox"/> ENTIRE RECORD EXCLUDING NURSES NOTES | | |

OTHER _____

ADDRESS OF PARTY TO WHOM INFORMATION IS TO BE RELEASED:

NAME _____

ADDRESS _____

CITY STATE ZIP

FOR THE FOLLOWING PURPOSE: LEGAL MEDICAL CARE INSURANCE OTHER (DETAIL BELOW)

AND THAT PURPOSE ONLY. OTHER USE IS FORBIDDEN

PATIENT INFORMATION

Name	DOB	SS#	MR#/Acct#
Address			Telephone#
Date of Service(s) or All			

I acknowledge, and hereby consent to such, that the released information may contain alcohol/drug abuse treatment, alcohol/drug screen test results, psychiatric, HIV testing, HIV results, AIDS or sexually transmitted disease information.

I, the undersigned, have read the above and authorized the staff of Sweeny Community Hospital District to disclose such information as requested above. I understand that this authorization may be withdrawn by me at any time except to the extent that information has already been released pursuant to this authorization. I understand that when this information is used or disclosed according to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information. This authorization expires 180 days from the date signed below and covers only treatment(s) dates specified above.

SIGNATURE OF PATIENT DATE SIGNED

SIGNATURE OF LEGAL REPRESENTATIVE RELATIONSHIP REASON UNABLE TO SIGN

**MEDICAL RECORDS DEPARTMENT
 SWEENEY COMMUNITY HOSPITAL DISTRICT
 305 NORTH MCKINNEY
 SWEENEY, TX 77480**

(979) 548-1592

FAX (979) 548-5230