Yoakum Community Hospital

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

AUTHORIZATION FOR: ☐ DISCLOSURE ☐ INSPECTION ☐ AMENDMENT OF PROTECTED HEALTH INFORMATION

Name of Patient:	Date of Birth:	SS No.:	MR No.:
Address:		Telephone No.:	

I hereby authorize: _____
(Name of Facility)

to release information from the medical records of: _____
(Name of Patient)

to: _____
(Name and Address of Person / Organization to which disclosure is to be made)

Fax Number: _____ Telephone Number: _____

For treatment dates: _____ Email: _____
(Specify dates – this line **MUST** be completed)

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (detail below)

SELECT PORTIONS

- ☐ Abstract / Pertinent Information
- ☐ Lab
- ☐ Emergency Room
- ☐ Imaging / Radiology Report
- ☐ Radiology Images
- ☐ Nursing Notes
- ☐ H & P
- ☐ Cardiac Studies
- ☐ MD Progress Notes
- ☐ MD Orders
- ☐ Face Sheet
- ☐ Operative / Procedure Report
- ☐ Entire Record **EXCLUDING** HIV Testing and Chemical Dependency
- ☐ Entire Record **INCLUDING** HIV Testing and Chemical Dependency
- ☐ Entire Record **INCLUDING** HIV Testing only
- ☐ Entire Record **INCLUDING** Chemical Dependency only
- ☐ Itemized Bill
- ☐ Other: _____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only the treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Yoakum Community Hospital to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. The hospital will not require individuals to waive their rights as a condition of the provision of the treatment, payment, enrollment in a health plan, or eligibility of benefits. I hereby release and hold harmless the above-named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____
Signature of Patient / Parent / Conservator / Guardian — Date — Time

_____ _____
Authority / Relationship to Patient — Witness

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual — Date

Fees / charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.

DOB: HSV:
AGE: SEX:
ADMIT: RM/BED: /
ADM: #:
MR #: PAT #: