USMD HOSPITAL AT ARLINGTON

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____ Phone Number: _____

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

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: _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical ☐ Consultation Report ☐ Emergency Room Record
☐ Operative Reports ☐ Discharge/Death Summary ☐ Face Sheet
☐ Lab/Pathology Reports ☐ Radiology Reports ☐ Discharge Instructions
☐ Radiology Images ☐ Other: _____

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

☐ Paper ☐ Electronic media
(requires 2 business days; only applies to data stored electronically)

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via a telephone call when records are ready for pick up.)

☐ Mail to Address below

Hospital Name:_____May release the above information to Name: _____

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

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 in reliance upon the authorization. I understand I may be charged retrieval/processing fee and for copies of my medical records according to the 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 unles otherwise specified by date, event, or condition as follows: _____

Signature: _____
Patient or Legally Authorized Representative

Printed Name: _____
Patient or Legally Authorized Representative

_____
Relationship to Patient

_____
Date

_____
For departmental use: MRN/Acct. #

USMD HOSPITAL AT ARLINGTON
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