USMD HOSPITAL AT ARLINGTON

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: ______________________________ Phone Number: ______________

Other Names Used: ______________ Date of Birth: ______ Social Security Number: 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: ______________________________

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
801 West I-20 • Arlington, TX 76017
www.USMDArlington.com
888.444.USMD