RELEASE OF INFORMATION - Patient Authorization

Baylor Scott & White Surgical Hospital- Fort Worth
1800 Park Place Avenue
Fort Worth, TX 76110
Medical Records ph: 682-703-5659
Medical Records fax: 682-703-5661

Patient Name: **Patient Date of Birth:**

Patient Address:
Street City State Zip

Patient Phone Number: **Patient Social Security #:**

Today's Date: _____ **DATE OF SERVICE requested** _____

Information to be released (please select):

____ Discharge Summary	____ X-Ray & Imaging – Report only	____ Medication List
____ History & Physical	____ X-Ray & Imaging - CD/Film only	____ Admission Forms / Facesheet
____ Consultation Reports	____ Lab / Pathology Results	____ Billing Record (s)
____ Operative Report (s)	____ EKG	____ Entire Record
____ Anesthesia Record (s)	____ Emergency Room Record	

____ OTHER (Please specify) _____

Reason for Release:

☐ Continued Medical Care ☐ Insurance Verification ☐ Personal Files ☐ Legal

☐ Other _____

- I understand that by signing this release, confidential information may be revealed, such as alcoholism, drug abuse, HIV status and mental illness.
- I understand that this release will be valid for a period of 180 days, unless otherwise specified.
- Personal health information that is disclosed may be re-disclosed by the recipient but will no longer be protected by Federal Privacy Regulations.
- Baylor Surgical Hospital at Fort Worth does not require the patient to sign this release in order to receive treatment or payment or to enroll or to be eligible for benefits.
- This authorization for release of information can be revoked at anytime in writing.
- If a patient's personal representative signs this authorization, the authorization also **must** include a description of that person's authority to act for the patient. Further supporting documentation may be requested.

I, _____, authorize Baylor Scott & White Surgical Hospital-
(Name of patient or legal representative)

Fort Worth to release the above listed protected health information to the following (Texas Health & Safety Code 241.152 (b)):

Name:

Address:

Phone Number: **Fax Number (Physician office only)**:

Please provide via: ____Mail ____Pick up **Please provide records: ____on CD ____Paper Copies**

Patient Signature (sign):

Patient's Legal Representative (if applicable):

- Under **Texas Law &** the **HIPAA Privacy Rule**, we cannot release health care information about a patient to any person other than the patient or the patient's legal representative without the written authorization of the patient or legal representative.
- Under Texas Law, we have **15 business days** to respond to all release of information requests. (**Texas Health & Safety Code 241.154**) (**HIPAA Privacy Rule** = 30 days)
- The **HIPAA Privacy Rule** requires that authorizations for disclosure of protected health information be separate from any other authorization or consent form.
- **Senate Bill 667**, a disclosure authorization must be in writing, dated and signed by the patient.

For office use only: Date of Release _____ Completed by _____