BaylorScott&White | SURGICAL HOSPITAL FORT WORTH
Joint ownership with physicians

Release of Information - Patient Authorization

1800 Park Place Avenue
Fort Worth, TX 76110
Medical Records Phone: 682-703-5659
Medical Records eFax: 817-887-0736

Today's Date: _____ Date of Service: _____

Patient Name: **Patient Date of Birth:** **Phone Number:**

Patient Address:
Street *City* *State* *Zip*

Information to be released (please select):

- ☐ History & Physical
- ☐ Anesthesia Record(s)
- ☐ Radiology Report(s)
- ☐ Consultation Report(s)
- ☐ Operative Report(s)
- ☐ Medication List
- ☐ Progress Note(s)
- ☐ Discharge Summary
- ☐ Other (*please specify*): _____

Reason for Release:

□ **Continued Medical Care** □ **Insurance Verification** □ **Personal Files** □ **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 any time 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 Surgical Hospital at Fort Worth
(Name of patient or legal representative)
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

Patient Signature: **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.