

# Authorization For Release Of Information (Non-Baylor)

I hereby authorize \_\_\_\_\_ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name \_\_\_\_\_

Date of Birth   /         
MM MM DD DD YY YY YY YY

Last 4 of Social Security Number

Patient Address \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date(s) of Service (if known) \_\_\_\_\_

Description of information to be released: (Check  all that apply)

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission/Registration | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records                | _____                                 |
| <input type="checkbox"/> Nurse's Notes      | <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Laboratory Reports     | _____                                 |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Records    | <input type="checkbox"/> Billing Records        | _____                                 |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Radiology Films      |   |                                       |

Description of the purpose of the use and / or disclosure: \_\_\_\_\_

The health information described herein shall be released to: (Check  the appropriate category)

- Hospital  Physician  Insurance Company  Attorney  Patient  Other

Name \_\_\_\_\_ (Check  the appropriate delivery method)  
Address \_\_\_\_\_  Mail  
Phone Number \_\_\_\_\_  Fax (Healthcare Organization only)  
Fax Number \_\_\_\_\_  Pick-up Records  
 Other \_\_\_\_\_

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_ (Expiration date / event).

I further understand that I may revoke this authorization at any time by notifying \_\_\_\_\_ in writing at \_\_\_\_\_. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

When checked, I understand that the record is incomplete and additional documentation will continue to be added. I understand that I may request a complete copy at approximately 30 days post discharge.

Signature of Patient or Patient's Representative \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Patient's Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ or Legal Authority (attach supporting documentation)

PATIENT LABEL

## BAYLOR HEALTH CARE SYSTEM



BHCS-49233 (Rev. 08/10)

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