



## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Baylor Scott & White Health to disclose my individually identifiable health information as described below. 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.

I understand that this authorization will expire 180 days from the date of signature or at the date or event specified here \_\_\_\_\_ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, the Baylor Scott & White Health facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another health care provider.  I would like to review my record

Patient Name	Last 4 of Social Security Number	Date of Birth MM MM / DD DD / YY YY YY YY
Street Address	City, State, Zip	Telephone Number

Please release information from these BSWH facilities: \_\_\_\_\_

Please release the following information for these treatment dates: \_\_\_\_\_

The information will be released to:  Patient/Designee  Health Care Entity  Insurance Company  Attorney  Other

Individual/Organization Name	Telephone Number
Street Address	City, State, Zip Fax Number

Purpose of the use and/or disclosure:  Continued Care  Legal  Insurance  Personal Use  Other \_\_\_\_\_

Record copy format:  Paper  CD  \_\_\_\_\_ Record copy delivery:  Pick-up  Mail  Fax to healthcare office

### Information to be released:

Include this information if applicable: \_\_\_\_\_ Alcohol/Drug \_\_\_\_\_ Genetics \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ Mental Health  
PT INITIALS PT INITIALS PT INITIALS PT INITIALS

- Summary Abstract only (clinic notes, history/physical, procedure reports, pathology, consultations, test results, discharge summary)
- Emergency Department  Discharge Summary  Medication  Provider Orders
- Billing Record  History/Physical  Nurses' Notes  Radiology Film
- Complete Chart  Immunization  Operative Reports  Radiology Reports
- Consultations  Laboratory  Progress Notes
- Other: \_\_\_\_\_

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

Signature of Patient or Legal Representative (electronic signatures not acceptable) \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Patient or Legal Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Representative's Authority to Act for Patient (attach supporting documentation)

