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 DD YYYY	Acct #	MRN
Street Address City, State, Zip			Telephone Number	

Please release information from these BSWH facilities: BAYLOR SCOTT & WHITE MEDICAL CENTER - CARROLLTON

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 (PT INITIALS) ------- Genetics (PT INITIALS) ------- HIV/AIDS (PT INITIALS) ------- Mental Health (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)

**** REMIT BACK WITH A COPY OF YOUR ID OR SUPPORTING DOCUMENTATION, IF APPLICABLE****