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)

____ Emergency Room
____ History & Physical
____ Nurse's Notes
____ Progress Notes
____ Discharge Summary
____ Radiology Reports
____ Consultation Reports
____ Physician's Orders
____ Operative Records
____ Radiology Films
____ Admission/Registration Records
____ Laboratory Reports
____ Billing Records
____ Other: ______________

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 ______________________________

Address ______________________________

Phone Number ______________________________

Fax Number ______________________________

(Check ✓ the appropriate delivery method)

____ Mail
____ Fax (Healthcare Organization only)
____ 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

______________________________ or ______________________________
Relationship to Patient Legal Authority (attach supporting documentation)

PATIENT LABEL

BAYLOR HEALTH CARE SYSTEM

BHCS-49233 (Rev. 08/10)

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