Authorization of Release of Patient Information

Consent To Release/Obtain PHI

Patient Name: _____ **Phone Number:** _____

Other Names Used: _____ **Date of Birth:** _____ **Social Security Number:** XXX-_____-_____

Date of Service: _____

I, the undersigned, authorize the release of or request access to the information below from the medical record (s), of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

☐ Continuing Medical Care ☐ Military ☐ Personal Use ☐ School ☐ Insurance ☐ Legal Purposes
☐ Social Security/Disability ☐ Other: _____

DATE (s) of TREATMENT: _____

☐ History and Physical
☐ Operative Reports
☐ Lab/Pathology Reports
☐ Behavioral Health
☐ Physician Progress Notes
☐ Consultation Report
☐ Discharge/Death Summary
☐ Radiology Reports
☐ Radiology Images
☐ EKG
☐ Emergency Room Record
☐ Face Sheet
☐ Discharge Instructions
☐ Other: _____

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

☐ Paper ☐ CD (requires 5 business days, only applies to data stored electronically)

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via telephone call when records are ready for pick up)
☐ Mail to Address listed below ☐ Fax to number listed below ☐ Mail to Alternative **Confidential Address** below

JPS Health Network / Acclaim may release the above information to:

_____
Name Phone Number

_____
Address (Street, State, Zip Code) Fax Number

I understand that the records and disclosed pursuant to this authorization form may include information related to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that JPS Health Network has already relied on this authorization. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires 180 days from the date of signature. I understand that JPS Health Network may not condition treatment on my completion of this authorization form.

I hereby revoke all previous authorization for disclosure to _____ to be effective this _____ day of _____, 20_____.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
For Department Use: MRN / CSN

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship