TEXOMA MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

1. Release information from the hospital record of:

Patient's Name – please print _____ Date of Birth _____ Social Security No. _____

Date of Treatment(s) _____ Telephone Number _____

2. I hereby authorize _____ to release information to:
(sending hospital)

_____
(receiving entity)

_____
(address of receiving entity)

3. Medical Records will not be released until they are complete. (Exception: Records required for continuation of care may be released to a designated caregiver prior to completion.)
Return date of completed records (15 days).

4. Information to be released.

_____	Face Sheet	_____	Doctor's Orders	_____	Chart Abstract
_____	Emergency Room	_____	Laboratory Reports		
_____	History & Physical	_____	Radiology Reports		
_____	Discharge Summary	_____	EKG, EEG		
_____	Operative Report	_____	Nurse's Notes		
_____	Pathology Report	_____	Entire Chart		
_____	Doctor's Notes	_____	Other: _____		

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specific information to be disclosed may include but is not limited to history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.

6. Patient information is needed for (Please check one):

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

7. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This authorization will expire 180 days from the date of my signature or as otherwise specified by date, event or condition as follows: _____

8. I further authorize that a photocopy of this authorization is acceptable as an original.

9. I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. ***Also, I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.***

x_____	x_____	x_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date	Time
_____	_____	_____	
Signature Acknowledgement of Receipt of Records	Number of pages	Date of Receipt or Transmittal of Records	

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

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