

# Authorization to Release Protected Health Information

**TO BE SCANNED**

Hospital ROI

This form collects information that is part of the medical record.

MR Number	Name (First, Middle, Last)	Birth Date (Month DD, YYYY)
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**Instructions:** If any section is incomplete, this form may be invalid.

**Release Information From**

**Release Information To**

Val Verde Regional Medical Center

Other (Specify facility/individual & address below, including phone/fax if known.)

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@S\_ W \_\_\_\_\_

Other (Specify facility/individual & address below, including phone/fax if known.)

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**Purpose of Release**

<input type="checkbox"/> Treatment/Continued Care	<input type="checkbox"/> Personal	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Payment of Insurance Claim
<input type="checkbox"/> Other		

**Information To Be Released**

(Required - check all that apply)

<input type="checkbox"/> 7 f d W M a d V	<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> History and Physical	<input type="checkbox"/> EKG's	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> Hospital Notes	<input type="checkbox"/> 5a` eg`fa`a` /efi	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Billing Information
<input type="checkbox"/> Other (specify information to be released in the space TWVW)			

Service Dates (Optional) From _____ To _____	Information Needed By (Optional) _____
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I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire 6 months from the date of signing unless I indicate an earlier date or event here: \_\_\_\_\_.

**ATTENTION:** This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  - Legal Guardian or Conservator       Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  - Parent       Legal Guardian

<b>Signature (Required)</b>	<b>Date Signed (Required) (Month DD, YYYY)</b>		
Printed Name of Person Signing (If Not Patient)			
Mailing Address of Patient - Street			
City	State	ZIP Code	Phone