Authorization for Release of Information

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 (including 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 for health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____

Print Patient Name | Date of Birth | Social Security Number

_____

Dates(s) of Service (if known) | Medical Record Number

Description of information to be released: (check all that apply)

- ❑ Face Sheet
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Consultation Reports
- ❑ Operative Reports
- ❑ Radiology Reports
- ❑ Laboratory Reports
- ❑ Pathology Reports
- ❑ Diagnostic Reports
- ❑ Emergency Room
- ❑ Radiology Films (Imaging Department)
- ❑ Billing Records (Patient Financial Services)
- ❑ Other: _____

_____

_____

The purpose of the disclosure is for the following: (check the appropriate category)

- ❑ **Patient Request: (circle type of disclosure)**

  Hospital Physician Insurance Attorney

  Other Please explain: _____
- ❑ **Hospital Request**: Explain purpose of authorization _____

(If a hospital request, the patient must receive a copy of the authorization)

The information described herein will be sent to the following address: (if applicable)
CCRLegal, 3303 Northland, Suite 200, Austin, Texas 78731

I understand that this authorization will expire 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____.

(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying said hospital in writing. 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.

_____ _____

Signature of Patient or Patient's Representative | Date

_____

Printed name of Patient's Representative

_____ _____

Relationship to Patient | Legal Authority (attach supporting documentation)