# AUTHORIZATION TO RELEASE HEALTH INFORMATION

**Baylor Scott & White Medical Center Trophy Club**
2850 State Highway 114 East, Trophy Club, TX 76262
Medical Records ph: 817-837-4605 or 817-837-4606
Medical Records Fax: 817-837-4611

**Information to be released:** **Date of Service:**

_____ Discharge Summary
_____ History & Physical
_____ Consultation Reports
_____ Operative Reports
_____ Anesthesia Records
_____ Nurses Notes
_____ X-Ray & Imaging
_____ Lab Results
_____ EKG
_____ Immunization Record
_____ Medication List
_____ Admission Forms
_____ Consents
_____ Billing Records
_____ Other (Please Specify:) ______________________________________________

I, ____________________________, authorize Baylor Scott & White Medical Center at Trophy Club to release the above listed protected health information to the following:

Name:

Address:

Phone: Fax:

**Reason for Release**: Continued Medical Care Insurance Verification Attorney
Other: ____________________________________________

(TX Health & Safety Code 241.152 (Vernon 2001) requires the reason or purpose of the release to be stated)

- I understand that by signing this release, confidential information may be revealed, such as alcoholism, drug abuse, HIV status and mental illness.
- I understand that a copying fee may be charged. A one time courtesy copy to a physician for continued medical care will be provided free of charge. All copies after that are subject to standard copying fees set by the facility. The copying fee is waived for records used for supporting an application for disability or other benefits assistance under either Aid to Families with Dependent Children; Medicaid; Medicare; Supplemental Security Income; or federal Old-Age and Survivor's insurance.
- I understand that this release will be valid for a period of one (1) year, unless otherwise specified.
- Personal health information that is disclosed may be re-disclosed by the recipient but will no longer be protected by Federal Privacy Regulations.
- BSWMCTC does not require the patient to sign this release in order to receive treatment or payment or to enroll or to be eligible for benefits.
- This authorization for release of information can be revoked at anytime in writing.
- If a patient's personal representative signs this authorization, the authorization also **must** include a description of that person's authority to act for the patient.

Patient Name (please print):

Patient Signature (sign):

Patient's Legal Representative (if applicable):

Date of Request:_______________ Social Security #: _______/______/________ Patient DOB: ______/_______/_______

______Fax ______Mail _______Pick up - date _____________

* **Under Texas Law, we cannot release health care information about a patient to any person other than the patient or the patient's legal representative without the written authorization of the patient or legal representative.**
* Under Texas Law, we have 15 business days to respond to all release of information requests.

**OFFICE USE ONLY:**
Information released:____________________________________________

# of pages: ______________________ HIM staff releasing information: ______________________