Mail or fax **ONLY** to: Release of Information 8101 W. Sam Houston Pkway South, Suite 100, Houston TX 77072 Fax (855) 519-9683 Phone (855) 519-9682

Hand delivered authorizations are accepted at the facility where services were provided - Note: Include copy of valid photo ID with Authorization

All shaded areas must be completed for a valid authorization.

Patient Name:	**Birth Date:**	**Last 4 Digits SSN (optional):**
Patient Alias(s):	**Patient Contact Number:**	
Recipient's Name:	**Recipient's Phone:**	**Recipient's Fax:**
Recipient's Address (City, State, Zip):		

Request Delivery (If left blank, a paper copy will be provided): ❑ **Paper Copy** ❑ **Inspection of Records** ❑ **Electronic Media, if available (e.g., USB drive, CD/DVD, email) NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).**

Email Address (If email checked above. Please print legibly):

Purpose of disclosure:

Is this request for psychotherapy notes? ❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ❑ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
❑ Entire medical record **(or Portions)** ❑ Abstract ***(most common)*** ❑ Physician Orders ❑ Physician Progress Notes ❑ Physician Dictated Reports		❑ Clinical Test(s) ❑ Medication Sheets ❑ ED Information ❑ Admission Form ❑ Operative Documentation ❑ Other:_____		**Confidential Information** ❑ HIV Testing ❑ HIV & AIDS Documentation ❑ Psychiatric Documentation ❑ Alcohol & Drug Abuse Documentation	

I hereby authorize the Hospital marked below to release records to the recipient party designated above.

❑ Bayshore Medical Center (East Houston Regional Medical Center Campus)
❑ Clear Lake Regional Medical Center
❑ Mainland Medical Center (Campus of Clear Lake)
❑ Conroe Regional Medical Center
❑ Corpus Christi Medical Center (Bay, Bayview, Doctors, Heart and Northwest Campuses)
❑ Kingwood Medical Center
❑ Rio Grande Regional Hospital
❑ Texas Orthopedic Hospital
❑ Other:_____
❑ The Woman's Hospital of Texas
❑ Valley Regional Medical Center
❑ West Houston Medical Center

I hereby release the Hospital designated above from any and all legal liability and injuries that arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service and/or electronic facsimile in accordance with the hospital's facsimile (fax) policy.

This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:
Expiration Date: **or** **Expiration Event**:

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. A copy or facsimile (fax) of this authorization is valid as the original.
3. I was given a copy of this form after I signed it.
4. My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.
5. This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization, contact the release of information personnel at 1-855-519-9682.

Unless I specifically mark below that I do not consent, I am expressly consenting to the release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, genetic information, or such disclosure shall be limited to the following specific types of information: I DO NOT CONSENT [ ]

Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ❑ Yes ❑ No
If yes, the health plan or health care provider must complete below, otherwise skip to signature.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ❑ Yes ❑ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ❑ Yes ❑ No

I have read the above or had it read to me and I authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative: **Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*	**Relationship to Patient:**

Identification Verified by:_____ ❑ State Issued Photo Identification ❑ Other_____

To the Party Receiving this Information: This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) Rev. 10/2013