AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

NAME OF PATIENT:		**PATIENT DATE OF BIRTH:**	
PHONE NUMBER:		**DATE(S) OF TREATMENT**	

I authorize Baylor Scott & White Medical Center – Frisco (Facility) to use or disclose the information specified below from the medical record of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

☐ Continuing Medical Care ☐ Personal Use ☐ Legal Purposes

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical/Consult ☐ Discharge Summary ☐ Radiology Images ☐ Operative Reports ☐ ER Records
☐ Lab Reports ☐ Pathology Reports ☐ Radiology Reports ☐ Discharge Instructions ☐ Medication
☐ Billing Records ☐ Abstract (these documents generally used for continuing care)
☐ OTHER _____ (fees may be associated with requests for complete chart copies)

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via telephone at the number provided above when records are ready for pick up)

☐ Mail to Address listed below ☐ Fax to healthcare provider at: _____ ☐ CD (may take up to 3 business days)

_____
(Name)

_____
Address (Street, State, Zip Code) Phone Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that I may inspect or copy the information to be used or disclosed in response to this authorization.

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. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon the authorization, by writing the Facility Privacy Officer at: 5601 Warren Parkway, Frisco, TX 75034. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:
_____.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize the Facility to use or disclose my health information in the manner described above.

Date: _____ **Signature:** _____
Patient or Legally Authorized Representative (electronic signature not acceptable)

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient

Baylor Scott and White Medical Center - Frisco | HIM Dept | 5601 Warren Parkway | Frisco, TX | 75034
T:214.407.5375 | F:214.407.5389

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