PALESTINE REGIONAL MEDICAL CENTER

RELEASE OF INFORMATION

☐ **AUTHORIZATION** ☐ **REQUISITION** *(Check one)*

SECTION A: This section to be completed by the patient.

Name of Patient:	Medical Record Number:	Social Security Number:	Date of Birth:
Address:			
City:		State:	Zip Code:

Releasing Facility	Facility Name:			
	Address:			
	City:	State:	Zip:	Telephone Number:
Requesting Facility or Individual	Requestor Name:			
	Address:			
	City:	State:	Zip:	Telephone Number:

Date(s) of Service: thru

List Specific Description of Information to be Released:

☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐ Other: _____
☐ UB92	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ _____
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐ _____
☐ Consultation	☐ History & Physical	☐ Surgery / Progress Report	☐ Accounting of Disclosure	☐ _____

SECTION B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read / acknowledge the following statements:

I understand that the persons hereby authorized to use / disclose information will not condition treatment or payment on my providing this authorization.

I understand that this authorization will expire on _____.

I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.

I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.

I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.

I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, venereal disease, or mental disorders. "In accordance with federal regulation 42 CFR part 2: I also understand that release of any and all alcohol and/or drug abuse treatment that such information cannot be released without my specific authorization, except in special circumstances. Therapists notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations."

FOR OFFICE USE ONLY

Verified: ☐ Yes ☐ No By: _____

License No: _____ SS No: _____

Signature: ☐ Yes ☐ No

<ESIG:DESC=Patient or Rep>

Signature of Patient or Legal Representative Date and Time

If Patient Representative – please type in name

Basis for which representative has the authority to act for the patient

<ESIG:DESC=Witness>

Signature of Witness Date and Time