Matagorda Regional Medical Center Release of Information Authorization

104 7th Street Bay City, TX 77414 Phone: 979-241-5565 Fax: 979-241-5567

*Patient Name:	*Address:	*Social Security Number:
*Date of Birth:	*Email:	*Telephone Number:

I hereby authorize **Matagorda Regional Medical Center** to release information from the medical records of

_____ (patient) to:

☐ Self ☐ Physician ☐ Other (specify name and relationship) _____.

Phone Number: _____ (physician's) Fax Number: _____ (physician's)

Treatment dates from _____ to _____.

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the patient, the patient reaching the age of majority, permission withdrawn, or the following specific date (optional): Month _____ Day_____ Year_____.

Information to be disclosed:

☐ Labs/ Pathology
☐ Radiology Reports
☐ Radiology Imaging (CD)
☐ Emergency Room Visit
☐ History & Physical
☐ Discharge Summary
☐ Cardiac Studies/ EKG
☐ Operative Reports
☐ All Health Information
☐ Billing Records
☐ Medication Lists
☐ Other: _____
☐ Facesheet

Your initials are required to release the following:

_____Mental Health Records (excluding psychotherapy notes)

_____Genetic Information (Genetic Test Results)

_____Drug, Alcohol, or Substance Abuse Records

_____HIV/AIDS Test Results/ Treatment

Patient Signature_____Date_____

Representative Signature_____Relation:_____Date_____

Note: If a representative is signing the form, the relationship with the patient must be detailed along with a description of the representative's authority to act on behalf of the patient.

I understand that information released pursuant to this request will not include information relating to Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS): treatment for or history of drug or alcohol abuse: or mental or behavioral health or psychiatric care unless specifically requested and initialed above.

Matagorda Regional Medical Center will not condition treatment or payment on the basis of signing this authorization. Further details may be found in the Notice of Privacy Practices. I understand that if the requestor or receiver is not a health plan or health care provider or a HIPAA covered entity, the released information may no longer be protected by federal privacy regulations and may be redisclosed and may no longer be protected by federal or state privacy laws.

I may revoke this authorization at any time. The request must be done in writing. I understand that prior actions taken in the reliance on this authorization by entities that had permission to access my health information will not be affected.