RELEASE OF INFORMATION - Patient Authorization

Baylor Scott & White Orthopedic and Spine Hospital
707 Highlander Blvd
Arlington, TX 76015
Medical Records ph: **817-583-7021 or 817-583-7020**
Medical Records fax: **817-466-7249**

Patient Name: **Patient Date of Birth:**

Patient Address:
Street City State Zip

Patient Phone Number: **Patient Social Security #:**

Today's Date: _____ **DATE OF SERVICE requested** _____

Information to be released (please select):

____ Discharge Summary	____ X-Ray & Imaging – Report only	____ Medication List
____ History & Physical	____ X-Ray & Imaging - CD/Film only	____ Admission Forms / Facesheet
____ Consultation Reports	____ Lab / Pathology Results	____ Billing Record (s)
____ Operative Report (s)	____ EKG	____ Entire Record
____ Anesthesia Record (s)	____ Emergency Room Record	

____ OTHER (Please specify) _____

Reason for Release:

☐ Continued Medical Care ☐ Insurance Verification ☐ Personal Files ☐ Legal

☐ Other _____

- 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 this release will be valid for a period of 180 days, 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.
- Baylor Orthopedic & Spine Hospital 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. Further supporting documentation may be requested.

I, _____, authorize Baylor Scott & White Orthopedic & Spine Hospital
(Name of patient or legal representative)

to release the above listed protected health information to the following (Texas Health & Safety Code 241.152 (b)):

Name:

Address:

Phone Number: **Fax Number**:

Please provide via: ____Mail ____Pick up _____Fax

Patient Signature (sign):

Patient's Legal Representative (if applicable):

- Under **Texas Law &** the **HIPAA Privacy Rule**, 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. (**Texas Health & Safety Code 241.154**) (**HIPAA Privacy Rule** = 30 days)
- The **HIPAA Privacy Rule** requires that authorizations for disclosure of protected health information be separate from any other authorization or consent form.
- **Senate Bill 667**, a disclosure authorization must be in writing, dated and signed by the patient.

For office use only: Date of Release _____ Completed by _____