

Authorization for Release of Protected Health Information

I authorize the following facility(s):

- | | |
|--|--|
| <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Aubrey | <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Burleson |
| <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Murphy | <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Mansfield |
| <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Keller | <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Rockwall |
| <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Colleyville | <input type="checkbox"/> Baylor Scott & White Emergency Hospital – Grand Prairie |

to release information from the record of:

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip code

Patient Phone Number: _____

as described below, the information will be released to:

Facility/Person to Receive Records _____

Phone: _____ Fax/Email: _____

Address: _____
Street City State Zip code

I have been a patient at your facility or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

Place a check by types of records desired:

- | | | |
|--|---|---|
| <input type="checkbox"/> Entire clinical record | <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Physician Progress Reports |
| <input type="checkbox"/> Laboratory Reports/Tests | <input type="checkbox"/> Psychiatric/Psychological Evaluation | |
| <input type="checkbox"/> EKG Report | <input type="checkbox"/> Radiology Report | |
| <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Pathology Report | |
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Abstract (<i>history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports</i>) | |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing or other business records (<i>specify</i>): _____ | |
| <input type="checkbox"/> Other (<i>specify</i>): _____ | | |

HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

- | | | |
|---------------------------------------|------------------------------|--|
| <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> HIV | <input type="checkbox"/> Mental Health (Psychiatric) |
|---------------------------------------|------------------------------|--|

Reason for Request:

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Continuing treatment | <input type="checkbox"/> Employer | <input type="checkbox"/> Insurance | <input type="checkbox"/> Study/Research |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Disability | <input type="checkbox"/> I do not wish to disclose the reason | |
| <input type="checkbox"/> Other: _____ | | | |

Dates of Service for record requests: _____

This authorization will expire in six months or: _____

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

Authorization for Release of Protected Health Information

I understand that this authorization is subject to revocation at any time, except to the extent that Baylor Scott & White Emergency Hospital has already taken action in reliance upon it or to the extent previously disclosed within the HIPAA NOTICE OF PRIVACY PRACTICES for Treatment, Payment, and/or Business Operations. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and deliver to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive, and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature _____ Date _____ Time _____

If representative, give relationship and authority to act _____

****If authority to act is a Power of Attorney, supporting documentation must be included with this request.****

Identity of requestor verified via _____ Photo ID _____ Matching Signature _____ Other, Specify _____

Witness Signature _____ Date _____ Time _____

Witness Signature _____ Date _____ Time _____

All release of information requests must be sent directly to the corresponding facility. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

**Baylor Scott & White Emergency
Hospital – Aubrey**

Attn: Medical Records Dept.
26791 Highway 380
Aubrey, TX 76227
Phone: 972-347-2525
Fax: 972-347-6725

**Baylor Scott & White Emergency
Hospital – Murphy**

Attn: Medical Records Dept.
511 FM 544
Murphy, TX 75094
Phone: 214-294-6150
Fax: 972-423-4096

**Baylor Scott & White Emergency
Hospital – Keller**

Attn: Medical Records Dept.
620 S. Main
Keller, TX 76248
Phone: 214-294-6100
Fax: 817-431-4674

**Baylor Scott & White Emergency
Hospital – Colleyville**

Attn: Medical Records Dept.
5500 Colleyville Blvd.
Colleyville, TX 76034
Phone: 214-294-6350
Fax: 817-581-3427

**Baylor Scott & White Emergency
Hospital – Burleson**

Attn: Medical Records Dept.
12500 South Freeway
Burleson, TX 76028
Phone: 214-294-6250
Fax: 817-447-7030

**Baylor Scott & White Emergency
Hospital – Mansfield**

Attn: Medical Records Dept.
1776 US 287
Mansfield, TX 76063
Phone: 214-294-6300
Fax: 817-473-1965

**Baylor Scott & White Emergency
Hospital – Rockwall**

Attn: Medical Records Dept.
1975 Alpha
Rockwall, TX 75087
Phone: 214-294-6200
Fax: 972-722-2410

**Baylor Scott & White Emergency
Hospital – Grand Prairie**

Attn: Medical Records Dept.
3095 Kingswood Blvd.
Grand Prairie, TX 75052
Phone: 972-854-0009
Fax: 972-606-4770