AUTHORITY TO REVIEW AND/OR RELEASE PROTECTED HEALTH INFORMATION

AUTHORITY IS HEREBY GRANTED TO _____

(FACILITY RELEASING INFORMATION)

AT _____

(ADDRESS) (CITY) (STATE) (ZIP CODE)

TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME, SPECIFICALLY:

□ FACE SHEET	□ BILLING RECORD	□ HISTORY AND PHYSICAL	□ DISCHARGE SUMMARY
□ DOCTOR'S ORDER	□ OPERATIVE REPORT	□ PROGRESS NOTES	□ CONSULTATION REPORT
□ LAB REPORTS	□ X-RAY REPORTS/FILM	□ CARDIOPULMONARY REPORTS	□ PATHOLOGY REPORT
□ ER RECORD	□ EMS RECORD	□ MEDICATION RECORDS	□ DISCHARGE INSTRUCTIONS
□ ENTIRE RECORD	□ ENTIRE RECORD EXCLUDING NURSES NOTES		

□ OTHER _____

_____

(NAME OF PARTY TO WHOM THE INFORMATION IS TO BE RELEASED)

_____

(ADDRESS)

_____

(CITY) (STATE) (ZIP CODE) (PHONE NUMBER)

FOR THE FOLLOWING PURPOSE: □ LEGAL □ MEDICAL □INSURANCE □ OTHER (DETAIL BELOW)
AND THAT PURPOSE ONLY _____

(**OTHER USE IS FORBIDDEN)**

PATIENT INFORMATION

NAME	DOB	SS#	MEDICAL RECORD #
ADDRESS			TELEPHONE #
DATE OF SERVICE(S) AND ACCOUNT NUMBER(S)			# OF PAGES RELEASED

_____I acknowledge and hereby consent to such, that the released information may contain alcohol/drug abuse treatment, alcohol/drug screen test results, psychiatric, HIV testing, HIV results, AIDs or sexually transmitted disease information.

I, the undersigned, have read the above and authorized the staff of Sweeny Community Hospital District to disclose such information as requested above. I understand that this authorization may be withdrawn by me in writing at any time except to the extent that information has already been released pursuant to this authorization. I understand that when this information is used or disclosed according to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, and any person who may have interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information. This authorization expires 180 days from the date signed below and covers only treatment(s) dates specified above.

Please provide picture I.D.

_____

SIGNATURE OF PATIENT DATE SIGNED

_____

SIGNATURE OF LEGAL REPRESENTATIVE RELATIONSHIP REASON UNABLE TO SIGN

SWEENY COMMUNITY HOSPITAL
305 N MCKINNEY
979-548-1592 SWEENY, TX 77480 FAX 979-548-5230