Moore County Hospital District
Health Information Management Department (Medical Records)
224 E 2nd Street
Dumas TX 79029
Phone: 806-934-7850 Fax: 806-935-3152
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RELEASE OF PATIENT INFORMATION CONSENT FORM released from MCHD

Release Information to:_____

Address: _____
City State Zip Code

Phone: _____Fax: _____Email: _____

Reason for Release: ____ personal ____ continued care other please describe _____

Please initial: _____

ID required to match name and address Please attach ID
Must be filled out completely and witnessed

I hereby authorize Moore Count Hospital District to furnish the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury. I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Moore County Hospital District in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization expires on the last day of the year it is signed. I further understand that I have a right to receive a copy of this authorization upon request.

Identifying Information: ***Hospital Employee _____ yes/no***

Patient's Name at Time of Treatment: (Please Print)_____

Address: _____City: _____ State: _____ Zip: _____

Date of Birth: _____ DL#_____

Date of Treatment: _____ or if long term ***Beginning – Dec 31, 2024***

Information Requested:

❑ Discharge Summary ❑ History and Physical ❑ Operative Report ❑ X-ray ❑ Consultation

❑ Clinical Laboratory ❑ EKG, EEG ❑ Progress Notes ❑ Other: _____

Signed:_____ _____
Patient, Parent/Legal Guardian Date

_____ _____
Witness signature Date

☐ Was information given to patient? How would they like to receive it: ☐ MAIL ☐ FAX ☐ EMAIL

INTERNAL USE ONLY:
Medical Record # _____ Account # V_____ AV #_____ ROI#_____