LBJ Tropical Medical Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary.

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

Telephone Work: _____ Home _____ MRN: _____

This authorization covers the period from: _____ to: _____ (Dates)

1) I would like to: ☐ Copy ☐ Send the Following Information ☐ Review

____Complete Record	____Progress Notes	____ History, Physical
____Discharge Summary	____ Pathology Report	____ Laboratory Test Results
____Surgery Reports	____Emergency Visit	____ Consultation Report
____HIV or AIDS	____ Pre-Natal Notes	____ X-Ray Reports
____Treatment for alcohol and/or Drug Abuse		____ Pharmacy Records
____Photographs, Videotapes, Digital or other Images		
____Mental Health or Psychiatric Services (Excluding Psychotherapy Notes)		

Note: Release of Psychotherapy Notes, as defined by HIPAA Regulations, requires a separate authorization.

2) If my records contain any information about: _____

____ **I do (or)** ____ **I do *not*** authorize the release of this information. **INITIALS:** _____

3) This information is to be disclosed for the purpose of:

____Continuing Health Care ____Insurance ____Legal Purpose

____Other(Specify)_____

To: Name: _____ **Telephone:** _____ **Fax:** _____

Address: _____

P.O. Box or Village

4) I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

5) LBJTMC, its employees, officers, and physicians are released from any legal responsibility or liability for the requested information as authorized.

6) The patient or the patient's representative must read and initial the following statements:

A) Initials_____ I understand that this authorization will expire on __/___/___ or upon the following event or condition_____ unless revoked earlier.

B) Initials_____ I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorizaiton will not apply to any information released by this facility before they received the revocation. (See our Notice of Privacy Practicies for instructions)

Signature:_____ **Print Name**_____ **Date:**____/___/_____

If signed by someone other than the patient, please describe your authority to act on behalf of the Patient:_____

You may refuse to sign this authorization; LBJTMC will not condition treatment or payment, on the authorization being signed.