Sundance HOSPITAL
Rebuilding Lives

7000 US HWY. 287
Arlington, Texas 76001
(817) 583-8080
www.sundancehealthcare.com

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Name:_____

_____
Date of Birth

2. * I hereby authorize the following individual/organization:_____Sundance Hospital_____

Address: _____7000 US Hwy 287 Arlington, TX 76001_____ to release to:

3. *_____
(Name of Individual/organization)

_____
(Address)

_____ _____
(Area Code and Phone Number) (Area Code and Fax Number)

4. *For the following purpose:_____

5. *INFORMATION TO BE RELEASED: **6.*** _____
Treatment Dates(s)

_____ Face Sheet	_____ TX Plan	
_____ H&P	_____ Physician's Orders	_____ Consults
_____ Discharge Summary	_____ Physician's Notes	_____ Lab(s)
_____ Psych Eval	_____ Nurse's Notes	_____ EKG
_____ Psych Test	_____ Therapy Notes	_____ Entire Chart

_____ Other _____

7. * I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.

8. * I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department (H.I.M.). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days (six months).

9. * I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Sundance Hospital Health Information Management Department.

10.* _____ **11. *** _____
Signature of Patient or Legal Representative Date

12.* _____ **13.** _____
If signed by Legal Representative, Relationship to Patient Signature of Witness