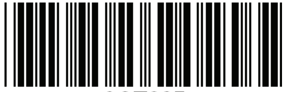
CST025

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Methodist Hospital and Methodist Women's Hospital

Patient's Name ______________/_____________ Phone No. _________________ Birth Date ______________
(Maiden/Previous Name)

I, the undersigned, do authorize and request ____
(Name of Health Care Provider)

to release to ____
(third party payer, other person, or organization)

____
(city, state, zip)

information form my medical records for the care and treatment that I received on: ____________________
(Date of Treatment)

☐ *Drug or Alcohol Abuse
☐ *Mental Health Treatment
☐ *HIV/AIDS-related Information
☐ Acute Hospital Care
☐ Other (please specify) ___________________________

*I understand that confidentiality of these records will be protected in compliance with state and/or federal law. No information will be released without my written consent unless disclosure is permitted by a court order, or to medical personnel in a medical emergency or for research/monitoring programs. In the case of mental health treatment, this authoization does not change my involuntary/voluntary legal status, but permits release to the insurer. Without this release, I will be personally responsible if the county declines payment.

Purpose: Mark the appropriate box with an "X" to indicate the reason the record is being requested:

Continuing Care ☐ Attorney ☐ Personal ☐ Workman Comp ☐ At request of the individual ☐
Other ☐ (specify) ___________________________

The following may be released:

☐ Discharge Summary
☐ History and Physical
☐ Consultations
☐ Operative Report
☐ Delivery Record
☐ Emergency Room Report
☐ Anesthesia Record
☐ Doctors Order/Progress Notes
☐ Pathology Report
☐ Lab Reports
☐ Radiology Reports
☐ EKG's
☐ Nurses Notes
☐ Dismissal Instructions
☐ Social History
☐ Rehab Therapy Notes
☐ Nursing Flow Sheets
☐ Entire Record
☐ Other ____

This authorization is effective until ________________________ or for 365 days from the date on which it is signed, whichever is longer. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health information Management of the releasing health care provider. If authorizing discloosure of mental health records, I understand that I have the right to inspect the information to be disclosed upon proper notification and under appropriate conditions established by the releasing health care provider. Methodist Hospital System and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by State law for mental health records and AIDS related information, federal requirements (42 C.F.R. Part 2) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes.

PATIENT LABEL

I acknowledge that I have received a copy of this authorization.

____
(Signature of Patient or Patient's Authorized Representative)

____
(Date & Time)

____
Relationship of Authorized Representative

____
Reason if signed by other than patient

PERMANENT PART OF THE MEDICAL RECORD **White - Hospital** **Yellow - Patient**