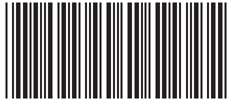
Document Type: Request for ROI



ROI001

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Methodist Hospital, Methodist Women's Hospital and Methodist Jennie Edmundson

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)

____
ADDRESS CITY STATE ZIP

information from 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 authorization 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:

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

☐ Continuity of care document ______________________________ Email ______________________________

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 disclosure of mental health records, I understand that I have the right to inspect the information to be disclosed upon proper notification an 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.

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

Patient Label

____
Reason if signed by other than patient

Form# 10RELEASE Rev 3/2013

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