AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: Baylor Scott & White Medical Center – Sunnyvale Telephone: 972.892.6270
231 South Collins Rd
Sunnyvale, TX 75182

To Release To: _____

_____

The following information from the medical record of:

Patient Name: _____ Social Security Number :_____
(First Name Last Name)

Date of Birth: _____ Date(s) of Treatment: _____

Information to be released:

- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ ER Records
- ☐ Complete Chart
- ☐ Other (specify):
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Abstract/Basics
- ☐ Operative Record
- ☐ EKG/ECHO
- ☐ Radiology reports
- ☐ Face Sheet
- ☐ Pathology Report
- ☐ Blood Type
- ☐ Radiology films/CD
- ☐ Itemized Bill

The information specified above is to be released for the following purpose:

☐ Treatment/Consultation ☐ Patient Request ☐ Billing or Claims ☐ Attorney ☐ Social Security
☐ Other (specify):

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ☐ YES − Okay to release ☐ NO − Do not Release

Time Limit and Right to Revoke

I understand this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new authorization. I desire this authorization to be in effect until _____ (expiration date/event). Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address.

Authorization and Re−disclosure

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign this authorization form. I understand the information disclosed by this authorization may be subject to re−disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize Baylor Scott & White Medical Center – Sunnyvale to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

☐ When checked, I understand that the record is incomplete and that additional information may continue to be added. I understand that I may request a complete copy of the record once the chart has been completed.

Preferred method of Reproduction: ☐ CD ☐ Paper The hospital will try to accommodate preference where practicable.

_____
Signature of Patient or Legal Representative Date

_____
Authority to sign, if not Patient (Documentation may be required)

_____
Signature of Witness/Baylor Scott & White Medical Center – Sunnyvale Employee