Authorization for Release of Protected Health Information

Patient Name: _____ **DOB:** _____
Last First M.I. **SSN#:**_____
MR#: _____

I authorize:
- ☐ Hunt Regional Medical Center (903-408-1634)
- ☐ Hunt Regional Community Hospital (903-453-6558)
- ☐ Hunt Regional Home Care (903-408-1950)
- ☐ Other: _____

To release to: _____
Address: _____
_____
_____
Phone Number:_____
Fax Number: _____

This information is needed for the purpose of:
☐ Medical Care ☐ Insurance ☐ Litigation ☐ at the request of the individual ☐ Other _____

Date information is needed: _____. Information is to be sent via:
☐ Patient to pick up records ☐ Send by Mail ☐ Fax to _____

TREATMENT DATES TO BE INCLUDED: _____ **to** _____

Please check all applicable information requested:

☐ Demographics Sheet	☐ Consultation Reports	☐ Medication Records
☐ History and Physical	☐ MD Progress Notes	☐ Diagnostic Imaging Reports
☐ Discharge Summary	☐ Physician Orders	
☐ Operative Reports	☐ Nursing Notes	☐ Billing Records
☐ Pathology Reports	☐ EKG/Cardiographics	☐ Other (please specify)
☐ ER Records	☐ Laboratory Reports	_____

I understand that the information to be released may include information regarding a medical condition, which is protected by Federal Law. Unless you indicate otherwise, this information will not be released (if present) to the organization, agency, or individual named on this request. I (patient name) _____ authorize the release of information regarding:

☐ Drug Abuse/Dependence	☐ HIV Test Results	☐ Psychiatric Conditions
☐ Alcohol Abuse/Dependence	☐ HIV/AIDS/ARC infection	

I request and authorize the above named health care provider to release the information specified to the organization, agency, or individual named on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expires **180** days from the date signed. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The facility to whom this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that the information that is being released is subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Party **Date**
- ☐ **Durable Power of Attorney**
- ☐ **Legal Guardian**
- ☐ **Other:** _____

If the patient is unable to sign or is a minor, complete the following:
- ☐ **Minor of _____ age**
- ☐ **Unable to sign because:**

_____

_____ _____
Signature of Witness **Date**