AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name:____

Patient's Social Security #: _______________ Patient's Date of Birth_______/_______/________

I authorize and request <u>Hickory Trail Hospital 2000 N Old Hickory Trail, DeSoto, Texas 75115, (972) 298-7323 Secure Fax: (972)296-0794</u> to disclose protected health information identified below:

I request the following information be released:

Date(s) of Treatment Requested: ____

<u>The following information: (check all that apply)</u>

___ Discharge Summary ___ Psychiatric Evaluation ___ History & Physical

___ Aftercare Plan ___ Consultation ___ Lab/Radiology Reports

___ Other (specify): ____

<u>I request that the health information be released and disclosed to:</u>

Name:____

Address: ____

Telephone: ______________________________ Fax: ____________________________

<u>Purpose or reason this information is needed: (check all that apply)</u>

___ Determine Eligibility – SS Disability, etc. ___ Continuity of Care/Monitor Medical Status

___ Admission/Intake/Placement/Transfer ___ Legal Proceedings ___ Personal Use

___ Other (Specify): ____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of this information.

I understand I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I understand the information released in response to this authorization may be re-disclosed to other parties. I understand my treatment, payment for my treatment and enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization. I understand I may be charged a reasonable fee for copies of these medical records according to State and Federal Laws.

This authorization will expire in 90 days from the date signed below.

_____________________________________ _________________________________

Signature of Patient or Legally Authorized Representative Date

Address ____

Relationship to Patient:___________________________ Telephone No.________________