

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____

Patient's Last 4 digits of Social Security #: _____ Patient's Date of Birth _____/_____/_____

I authorize and request Hickory Trail Hospital 2000 N Old Hickory Trail, DeSoto, Texas 75115, (972) 298-7323 Secure Fax: (972)283-6204 to disclose protected health information identified below:

I request the following information be released:

Date(s) of Treatment Requested: _____

The following information: (check all that apply)

- Discharge Summary Psychiatric Evaluation History & Physical
- Aftercare Plan Consultation Lab/Radiology Reports
- Other (specify): _____

I request that the health information be released and disclosed to:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Purpose or reason this information is needed: (check all that apply)

- 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. _____