

KINGWOOD MEDICAL CENTER

An HCA Affiliated Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

All Sections Must be Completed for Valid Authorization

Patient's PRINTED Name:		Birth Date:	Date(s) of Service:	S.S. Number:
Street Address:		City:	State:	Zip:
Home Phone #: () -	Work Phone #: () -	Type of Access Requested: <input type="checkbox"/> Copies of Record <input type="checkbox"/> Inspection of Record		

Information Being Disclosed To

I hereby authorize _____ (Hospital) to disclose records obtained in the course of my evaluation and /or treatment to:

Name: _____ **Address:** _____

Phone #: () - _____ **Fax #:** () - _____ **Purpose of Disclosure:** _____

Description of Information to be Used or Disclosed

Medical Records: <input type="checkbox"/> All Treatment Notes <input type="checkbox"/> Face Sheet <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult Report(s)	<input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Pathology <input type="checkbox"/> Progress Notes <input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Cardiopulmonary	<input type="checkbox"/> Rehab Services <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Physician Orders <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Other	Billing Records: <input type="checkbox"/> Detailed Bill <input type="checkbox"/> UB 92 (Forward Copy to PAD for Processing) <input type="checkbox"/> Other
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I acknowledge, and hereby do consent/ do not consent to such, that the released information may contain alcohol, drug abuse, psychiatric, psychological testing, HIV testing, HIV results or AIDS information, or such disclosure shall be limited to the following specific types of information:

- I understand that:**
1. I may refuse to sign this authorization and that it is strictly voluntary.
 2. If I refuse to sign this authorization, my healthcare and the payment of my healthcare will not be affected.
 3. I may revoke this authorization at any time except to the extent that action has been taken and if not earlier revoked. If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department.
 4. Information disclosed by this authorization may be re-disclosed by the recipient of my PHI and that such re-disclosure will no longer be protected by this authorization.
 5. I have the right to receive a copy of this authorization. A copy or facsimile of this authorization is as valid as the original.
 6. This authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date of signature.

I hereby release Kingwood Medical Center from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. Mail Service and /or electronic facsimile in accordance with Hospital's facsimile policy.

I understand that the facility may not condition treatment, payment, enrollment or eligibility for benefits whether or not this authorization is signed.

I have read the above or have had it read to me and authorize the disclosure of the protected Health Information as stated.

Signature of Patient/Legal Guardian or Representative:	Date:
If signed by other than patient, indicate relationship	Witness:

To the Party Receiving this Information:
 This information has been disclosed to you from records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.

FOR OFFICE USE ONLY

Completed By:	Date Completed:
Medical Record #:	Account #: