

SCOTT & WHITE HOSPITAL - BRENHAM
700 MEDICAL PARKWAY, BRENHAM, TEXAS 77833
(979)830-7430 PHONE (979)830-7429 FAX

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize SCOTT & WHITE HOSPITAL - BRENHAM to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. 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 health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider; the released information may no longer be protected by federal and state privacy regulations.

Print	Patient Name	Date of Birth	Social Security Number
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Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

- Emergency Room Radiology reports Admission/Registration
 History & Physical Consultation reports records
 Nurse's notes Physician's orders Laboratory reports
 Progress notes Operative records Billing records
 Discharge summary Radiology films Other: _____

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to: Hospital Physician
 Insurance Company Attorney Patient Other (check the appropriate category)

Name	Address	City	State	Zip
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I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until

Expiration event/date

I further understand that I may revoke this authorization at any time by notifying TRINITY MEDICAL CENTER in writing at 700 MEDICAL PARKWAY, BRENHAM, TEXAS 77833. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions take before the receipt of the written revocation.

Signature of Patient or Patient's Representative

Date

Printed name of Patient's Representative

or

Relationship to Patient

Legal Authority (attach supporting documentation