MEDINA HEALTHCARE SYSTEM
Methodist HEALTHCARE | SAN ANTONIO

Authorization for Release of Information

Medina Regional Hospital | Medical Clinics of Hondo, Devine & Castroville

Incoming or Outgoing

Patient Identity

Patient Name: _____ Date of Birth: ____/____/____

Email: _____ Date of Service(s) Requesting: _____

Information to Be Released

☐ Paper copy ☐ Electronic format

☐ Emergency Room	☐ Radiology Reports	☐ Admission/Registration Records	☐ Radiology Films
☐ History & Physical	☐ Consultation Reports	☐ Laboratory Reports	☐ Other: _____
☐ Nurse's Notes	☐ Physician's Orders	☐ Billing Records	_____
☐ Progress Notes	☐ Operative Records	☐ Discharge Summary	_____

Purpose of Request

☐ At the request of the patient ☐ Treatment or Consultation ☐ Billing or claims payment

Release Information

Release To | The health information described herein shall be released **to:**

☐ **Hospital** ☐ **Physician** ☐ **Insurance Company** ☐ **Attorney** ☐ **Patient** ☐ **Other:** _____

Release to Name: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____ Fax: _____

☐ **Hospital** ☐ **Physician** ☐ **Insurance Company** ☐ **Attorney** ☐ **Patient** ☐ **Other:** _____

Release to Name: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____ Fax: _____

☐ **Hospital** ☐ **Physician** ☐ **Insurance Company** ☐ **Attorney** ☐ **Patient** ☐ **Other**: _____

Release to Name: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____ Fax: _____

Release From | The health information described herein shall be released **from:**

☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other: _____

Release from Name: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____ Fax: _____

Time Limit & Right to Revoke Authorization

☐ 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 _____.

☐ I understand that I may revoke this authorization at any time by notifying **Medina Regional Hospital in writing at 3100 Avenue E Hondo, Texas 78861, ATTN: Medical Records.** 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 taken before the receipt of the written revocation.

Disclosures

☐ I hereby authorize Medina Healthcare System to disclose my individually identifiable health information as described within, 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.

_____ _____

Signature of Patient or Patient's Representative Today's Date

_____ _____

Printed name of Patient's Representative Patient Identified By

_____ or _____

Relationship to Patient Legal Authority

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, Specify:** _____