GUADALUPE COUNTY HOSPITAL

# Authorization to Release Protected Health Information

## Patient Information

| PATIENT NAME | DATE OF BIRTH | LAST 4 OF SS# |
|---|---|---|
| | | |

## Requestor Information

| Requestor Phone Number | | Requestor Email | |
|---|---|---|---|

☐ **Patient (Self)**

☐ **Medical Entity / Insurance**

Entity Name

Contact Name

| ☐ **Representative / Other**<br>Name<br>Relationship to Patient | Please include appropriate documentation (i.e. Power of Attorney, Personal Representative, etc.) |
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## Release Information Method

| ☐ **Mail** (address, city, state and zip code) | |
|---|---|
| ☐ **Fax** (area code – phone number) | Fax #: |
| ☐ **Email** (Email Address, Link Password)<br>Include at least 10 characters for your password link.<br>Please include alpha, numeric and special characters.<br>Please do not use this password for any other account. | Email Address:<br>Password:<br>We will assign this password to your link containing your attached records. Be sure to remember it! |

☐ **In-Person Pickup**

## Information Authorized to be Disclosed

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| ☐ All Medical Records | ☐ Nurse's Notes |
| ☐ Physician Progress Notes | ☐ Imaging / Radiology Reports |
| ☐ History & Physical | ☐ Operative / Procedure Reports |
| ☐ Discharge Summary | ☐ Lab / Test Results |
| ☐ Physician Orders | ☐ Other |

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| Date(s) of Service Requested | |
| Purpose/Reason for Request | |

This authorization will automatically expire 365 days after the date of signing. You may limit this authorization to a shorter period if desired.

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| Authorization Expiration Date | |

☐ I understand that I may revoke or cancel this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation addressed to: HIM Department at **GUADALUPE COUNTY HOSPITAL** and I also understand that any information/PHI released previous to this revocation or cancellation has been released in good faith and is now in the records of a healthcare entity or provider as previously authorized.

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| ☐ I understand that PHI that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.<br><br>☐ I understand the Hospital is not responsible for any misuse/disclosure made by a third party to whom I have authorized release of my PHI.<br><br>☐ I understand that I have the right to request or inspect or copy my PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)<br><br>☐ I understand that I do not have to provide a reason for requesting release of my PHI.<br><br>☐ I understand that under HIPAA Privacy, my access to PHI may be restricted if appropriate for my care and treatment. |
| I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, **other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately** (unless this authorization pertains specifically to psychotherapy notes); information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization as stated above.<br><br>**INITIALS:** |

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| | |
| Requestor's Signature | Date |

You must include a copy of the patient's photo ID for verification purposes.

Medical Records may contact the requestor via phone or email for additional information regarding this form, if necessary.