MEMORIAL HOSPITAL
SEMINOLE HOSPITAL DISTRICT

209 NW 8th Street
Seminole, TX 79360
PH. (432) 758-4883

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I_____ who resides at_____

In the city of _____ In the state of_____hereby authorize:

NAME:_____

ADDRESS:_____

CITY, ST., ZIP:_____

to disclose the following medical information by: ☐ mail or ☐ fax or ☐ e-mail to:

NAME:_____ _____

(Physician, Hospital, Clinic, Lab, Radiology Center, OR Other Healthcare Provider, Health plan, Third Party Admin or Other Payer.)

ADDRESS:_____

CITY, ST., ZIP:_____

From the Health Records of:

NAME:_____

(Name of Individual Whose Health Record Is Being Disclosed)

ADDRESS:_____

CITY, ST., ZIP:_____

For the purpose of:_____

My authorization extends only to those data elements/documents initiated below:

_____ Statement of charges/payments
_____ Records of visits
_____ Record of visit for specific date
Specific dates include or limited to:_____
_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
_____ Emergency Room Record
_____ Progress Notes
_____ X-Ray Reports, Photographs, Video Tapes, Digital or other images.
_____ Discharge Summary
_____ History & Physical Examination
_____ Laboratory Tests
_____ Consultation Report
_____ Respiratory Therapy
_____ Physical Therapy_____
_____ Occupational Therapy_____
_____ Speech Therapy_____
_____ All of the above_____
_____ Other (Specify)_____
_____ Mental Health (psychological or psychiatric impairment) and/or alcohol and drug abuse Treatment (Chemical dependency)
_____ AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus)
_____ Hepatitis Information
_____ Contagious or venereal disease

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This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, expect as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for (180 days) six-month period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.

4. Seminole Hospital District, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may be conditioned upon obtaining this Authorization.

6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Patient Name Printed Date

_____ _____
Patient's Signature (or Guardian, if a minor) Expiration Date (no more than 180 days)

_____ _____
Social Security Number (for identification purposes only) Date of Birth

_____ _____
Patient's Personal Representative Date

_____
Patient's Personal Representative's Authority to Act

_____ _____
Witness Date