PARKLAND HEALTH & HOSPITAL SYSTEM

Dallas, Texas

AUTHORIZATION FOR

RELEASE OF INFORMATION

ARI260

Patient Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ MRN _____

Telephone # _____

I hereby authorize Parkland Health & Hospital System (PHHS) to release the information specified below from the medical record(s) of the above named patient.

Patient information is needed for (Please select only one):

☐ Continuing Medical Care ☐ Legal Purposes ☐ Insurance/Billing/Claims

☐ Personal Use ☐ Social Security/Disability ☐ Other, please explain: _____

Information to be released or accessed (Check ☑ all that apply):

☐ Consultation Reports ☐ Discharge Summary ☐ Emergency Room Record ☐ Face Sheet

☐ History and Physical ☐ Laboratory Reports ☐ Operative Reports ☐ Pathology Reports

☐ Progress Notes ☐ Radiology Reports ☐ Other: _____

Date of Service: From _____ to _____

Format requested for information be provided: ☐ CD (Only applies to data stored electronically) ☐ Paper

The information described above shall be released to:

_____
Name of Person/Organization

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Delivery Method:

☐ Mail

☐ Pick-Up

☐ Fax (Healthcare Organization Only)

I understand that my medical information may include sensitive health information. Communicable or venereal disease such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), if diagnosed, will be included in my medical record. I further understand that my medical information could indicate I am undergoing treatment for psychological or psychiatric conditions or substance abuse.

I understand that I may revoke this authorization in writing at any time, except to the extent that PHHS has relied on this authorization. The written revocation should be addressed to the PHHS Health information Management Division – Release of Information. Unless otherwise revoked, I understand that the date or event upon which this authorization expires is One Hundred and Eighty (180) days from the date of signature. A copy of this authorization is considered as valid as the original.

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

I understand that PHHS will not condition treatment, payment, enrollment, or eligibility for benefits based on completion of this form. I understand I may be charged retrieval/processing fee and for copies of medical record according to Texas Hospital Licensing Law.

_____ _____ _____ _____
Patient Signature Patient Printed Name Date Time

_____ _____ _____ _____
Legal Representative Signature Legal Representative Printed Name Date Time

_____
If representative, specify relationship to patient

_____ _____ _____ _____ _____
Interpreter Signature (if applicable) Interpreter Printed Name ID # Date Time