



This is a general authorization in which I give my permission to disclose and deliver any and all medical information contained in my medical records. This may include HIV (AIDS) test results, alcohol, drug abuse, psychological, psychiatric treatment and any related information. I understand I may be charged a retrieval/processing fee for copies of my medical records according to Texas Hospital Licensing Law.

Date of Request Patient Name Date of Birth Medical Record Number

Duration of Authorization will be 180 days from date of authorization.

To: United Regional
(Name of individual, program, or health care facility)

This is specifically the information you are authorized to release from my medical records:

Admission Date Admission Date Admission Date Admission Date Admission Date

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Other:
<input type="checkbox"/> History & Physical	<input type="checkbox"/> X-Ray Reports	_____
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physician's Orders	_____
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> ER Records	_____
<input type="checkbox"/> Report of Operation	<input type="checkbox"/> Entire Records	_____
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Entire Records, excluding Nurse Notes	

To Receive: _____
(Name of the individual, program, or health care facility)

Address: _____

Purpose: _____
(The authorization is for this purpose only, and any other use is strictly forbidden)

This consent for release of information from the above records is subject to revocation at any time except to the extent that action has been taken in reliance thereof, or in the event that this information has been furnished within the duration of this authorization as indicated above, at which time this authorization expires without expressed revocation.

Date signed Signature of patient or authorized person If other, please give relationship

Date signed Signature of verify receipt of medical record

PROHIBITION ON DISCLOSURE: This information is being disclosed for you from the records whose confidentiality protected by federal law. Federal Regulations (42 CFR Part 2) prohibits you from making further disclosures of this information except with the specific consent of the person to whom it pertains.