MIDLAND HEALTH

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name_____ Date(s) of Service_____

Date of Birth_____ Social Security Number_____

Physicians Group Practice Name: _____

Address _____ City _____ State_____ Zip _____

I, the undersigned, authorize the release of information from the facility specified above from the medical record(s) of the above named patient.

The information is released to: _____
(physician, hospital, attorney, insurance company, self, etc.)

Address_____ City_____ State _____Zip_____

Phone # _____ Fax # _____

PATIENT INFORMATION IS NEEDED FOR:

☐ Attorney/Legal
☐ Personal Use
☐ Worker's Compensation
☐ Continued Medical Care
☐ Social Security/Disability
☐ Other_____
☐ Insurance Company
☐ Military

INFORMATION TO BE RELEASED:

☐ Emergency Room Record
☐ Physician Orders
☐ Radiology Reports
☐ Other_____
☐ Progress Notes
☐ Pathology Report
☐ Operative Report
☐ Lab Reports
☐ Discharge Summary
☐ History and Physical
☐ EKG, EEG, EMG

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the law. I understand that the specified information to be released may include, but is not limited to, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that I may revoke this authorization in writing prior to the expiration date of 180 days (6 months) from the date of my signature to the extent that action has been taken in reliance upon the authorization. I understand that to revoke my authorization, I must send a written request to Midland Health.

Attention: Compliance /Privacy Officer: 400 Rosalind Redfern Grover Prkwy/ Midland, TX 79701/ or by fax (432-221-4252).

I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

I understand that Midland Health may not condition my treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization when the prohibition on the conditioning of authorizations set forth in 45 C.F.R. § 164.508(b)(4) applies. This authorization will expire one hundred eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:_____

Date_____ Signature_____
(Patient or Legally Authorized Representative)

Contact Phone Number _____

_____
(Relationship to Patient)

Description of Authority to act on behalf of patient (attach copy of any necessary legal documents):

_____

_____