Uvalde Memorial Hospital

MEDICAL RECORD RELEASE - ACUTE CARE

I hereby authorize Uvalde Memorial Hospital to use and disclose protected health information from the record(s) of:

Name: _____ Social Security No.: XXX-XX- _____ Date of Birth: _____

Medical Record No.: _____ Date(s) of Service: _____ to _____

To Whom: _____

For the purpose of: ☐ Medical Care ☐ Insurance ☐ Litigation ☐ Other _____

I specifically authorize use and disclosure of the following records: (Please Check)

History & Physical	☐	Pathology	☐	ER Visit	☐	Complete Medical Record	☐
Discharge Summary	☐	Laboratory	☐	Admission Facesheet	☐	Physician Orders	☐
Operative	☐	Radiology Reports	☐	Immunizations	☐	Medications	☐
Consultation	☐	EKG	☐	PT / OT / ST	☐	Other	☐

I understand that copies of the Records indicated above will be:

(check one) ☐ Mailed to: ☐ Hand Carried:

Name of Recipient: _____

Name of Company: _____

Address: _____

City, State, Zipcode: _____

Faxed to:

Name of Recipient: _____

Name of Company: _____

Fax Number: _____

Confirmation Phone Number: _____

Date of Release: _____

No. of Pages: _____ Released by: _____

* I understand that these records can include information about HIV / AIDS status, alcohol and substance abuse, and / or mental conditions. Uvalde Memorial Hospital is hereby released from legal responsibility or liability for the release of information to the extent authorized herein. This authorization extends to furnishing of copies of any / all parts of the record in order to comply with the request as stated above.
* I understand that to the extent any Recipient of this information , as Identified above, is not a 'covered entity' under Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy laws once it is disclosed to the recipient and , therefore, may be subject to re-disclosure by the Recipient.
* I understand that I may revoke this authorization in writing at any time except to the extent that Uvalde Memorial Hospital has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the designee of Health Information Services, 1025 Garner Field Road, Uvalde, Texas 78801 and / or fax to 830-278-2257, stating my intent to revoke this authorization.
* Unless otherwise revoked, I understand that this authorization is valid until the 180th day after the date it is signed unless it provides otherwise or unless it is revoked.
* I understand that completion of this authorization form is not a condition of treatment.

_____
Relationship

_____ _____
Printed Name of Patient or Authorized Representative Patient Signature or Authorized Representative Date/Time

_____ _____
Printed Name of Witness Witness Signature Date/Time

UVALDE MEMORIAL HOSPITAL