CARROLLTON REGIONAL MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Carrollton Regional Medical Center to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the 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 this authorization will expire 180 days from the date of signature or at the date or event specified here _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, Carrollton Regional Medical Center, where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there may be a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another health care provider.

Patient Name	Last 4 of Social Security Number	Date of Birth MM DD YYYY	Acct #	MRN
Street Address	City, State		Zip	
Telephone Number	Email:			

The information will be released to: ☐Patient/Designee ☐Health Care Entity ☐Insurance Company ☐Attorney □ Other

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: ☐Continued Care ☐Legal ☐Insurance ☐Personal Use ☐Other _____

Record copy delivery: ☐Fax to healthcare provider/facility ☐Mail ☐PDF via email ☐Pickup

□ Other _____

Information to be released from these CRMC facilities: ☐Carrollton ☐Fort Worth ☐Addison ☐Other_____

Please release the following information for treatment dates: _____

Include this information if applicable: ------- Alcohol/Drug PT INITIALS ------- Genetics PT INITIALS ------- HIV/AIDS PT INITIALS ---------- Mental Health PT INITIALS

□ Summary Abstract only (clinic notes, history & physical, procedure reports, pathology, consultations, test results, discharge summary)

□ Clinic Notes	☐Consultations	☐Laboratory	☐Radiology Images (CD only)
□ Emergency Department	☐Discharge Summary	☐Medication	☐Radiology Reports
□ Billing Record	☐History & Physical	☐Operative Reports	
□ Complete Chart **(Fee)**	☐ Immunization	☐Progress Notes	

□ Other: _____

I understand the record might not be complete and additional documentation could be added after submitting this request if it is a recent visit.

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Information request. I consider this as my electronic signature for this request.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient or Legal Representative | Relationship to Patient

_____

Representative's Authority to Act for Patient (attach supporting documentation)