

BAYLOR SCOTT & WHITE HEALTH AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Baylor Scott & White Health 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, the Baylor Scott & White Health facility 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: If you have requested records be sent to you directly, we will send you an email with a link to download them, unless you specify otherwise: Fax to healthcare provider/facility Mail PDF via email MyBSWHealth
 Other _____

Information to be released from these BSWH facilities: Clinic visits Hospital visits _____
(Specify Provider or Location)

Please release the following information for treatment dates: from _____ to _____

Include this information if applicable: _____^{PT INITIALS} Alcohol/Drug _____^{PT INITIALS} Genetics _____^{PT INITIALS} HIV/AIDS _____^{PT INITIALS} Mental Health

- 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) Scan doc type: Authorization to Release Protected Health Information

BAYLOR SCOTT & WHITE HEALTH



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