FRIO REGIONAL HOSPITAL

In Partnership with Methodist HEALTHCARE | SAN ANTONIO

AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME:_____
AGE:_____DOB:_____SEX:_____

PATIENT LABEL

MEDICAL RECORD #_____
ACCOUNT #_____

I hereby authorize_____to release the information specified
PHYSICIAN / HEALTH FACILITY

below relative to the following period of service:_____.
MONTH / YEAR OF TREATMENT

Name of Patient:_____

Address:_____
STREET / CITY / STATE / ZIP

Date of Birth:_____ SS#:_____ Phone:_____

Release To:_____for the purpose
FACILITY / INDIVIDUAL TO RECEIVE INFORMATION

of_____.

THE FOLLOWING INFORMATION IS TO BE RELEASED:

☐ Admission Face Sheet	☐ Lab Results	☐ Respiratory Treatment Notes
☐ Billing Records/Financial Information	☐ Medication Record	☐ Progress Notes
☐ Consultation Report	☐ Nurse's Notes	☐ PT/RT/OT Record
☐ Discharge Summary	☐ Operative Report	☐ X-Ray Reports
☐ Emergency Department Record	☐ Outpatient Record	☐ Other, please specify:_____
☐ History and Physical Exam	☐ Physician Orders	_____

I understand that upon release of the selected information above, this information may be subject to redisclosure by the recipient and Baptist Health System is not liable for redisclosure. The records to be furnished or reviewed include information concerning my case history and the treatment, examinations, or hospitalization, including but not limited to, any and all information related to testing, diagnosis and treatment for acquired immune deficiency syndrome (AIDS) or related disorders, if any. I, the undersigned, understand this information may include reference to psychiatric treatment or testing, evaluation, or treatment for substance abuse. The hospital, employees, and physician are released from liability for release of these records.

IMPORTANT — If patient deceased, please check one box below:

☐ I am the Administrator/Executor for the deceased and have attached the Letters / Testamentary.

☐ There is no court appointed Administrator/ Executor and I am the next of kin.

_____
SPECIFY RELATIONSHIP TO THE DECEASED

_____ _____ _____
SIGNATURE OF PATIENT DATE TIME

_____ _____ _____
SIGNATURE OF PATIENTS LEGALLY ASSIGNED REPRESENTATIVE (WHEN APPLICABLE) DATE TIME

_____
RELATIONSHIP TO PATIENT (WHEN APPLICABLE)

This information has been released to you from records where confidentiality is protected by Federal Law. Federal Regulations (42 Code of Federal Regulations, Part 2) prohibits you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A photocopy shall have the same effect as an original.

This authorization is subject to revocation at any time except to the extent that action has been taken. All requests for revocation must be in writing to the Health Information Management Department. This authorization shall expire upon release of the information for the purpose stated above, or 180 days (six months) from the date of signature, whichever occurs first.

Internal Use Only: ☐ Records Reviewed ☐ Copies Provided