

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Baylor Family Medical Center at Riverside to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. 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.

Print Patient Name \_\_\_\_\_  
 Date of Birth 

MM	MM	DD	DD	YY	YY	YY	YY

 Social Security Number 

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Patient Address \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Date(s) of Service (if known) \_\_\_\_\_

Description of information to be released: ( Check  all that apply )

<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Admission / Registration	<input type="checkbox"/> Other: _____
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Records	_____
<input type="checkbox"/> Nurse's Notes	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Laboratory Reports	_____
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Operative Records	<input type="checkbox"/> Billing Records	_____
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Films		_____

Description of the purpose of the use and / or disclosure: \_\_\_\_\_

The health information described herein shall be released to: ( Check  the appropriate category )

Hospital     Physician     Insurance Company     Attorney     Patient     Other

Name \_\_\_\_\_ ( Check  the appropriate delivery method )  
 Address \_\_\_\_\_  Mail  
 City, State, ZIP \_\_\_\_\_  Fax  
 Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  Pick-up Records  
 \_\_\_\_\_  Other \_\_\_\_\_

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_ ( Expiration date / event ).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative \_\_\_\_\_ Date \_\_\_\_\_  
 Printed Name of Patient's Representative \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ or \_\_\_\_\_ Legal Authority ( attach supporting documentation )

PATIENT IDENTIFICATION NO. \_\_\_\_\_  
 PATIENT \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_

**Baylor Family Medical Center at Riverside**  
**2740 North Highway 360**  
**Grand Prairie, Texas 75050**  
**972-606-8300 - Phone**  
**972-606-8312 - Fax**

**AUTHORIZATION FOR RELEASE OF INFORMATION (Rev. 10/04)**