CHILDRESS REGIONAL MEDICAL CENTER
P.O. BOX 1030
CHILDRESS, TEXAS 79201

PHONE (940) 937-6371
FAX (940) 937-9146

AUTHORIZATION FOR RELEASE OF INFORMATION

(Photocopies of this consent in its original form shall be acceptable)

Date of Request: ____________________

Patient Name: ____________________ **Date of Birth:** ____________ **SS#:** ____________

I hereby authorize ***Childress Regional Medical Center*** to release information related to the treatment of the above named patient.

INFORMATION TO BE RELEASED: (Please check information requested)

___Discharge Summary ___X-ray/Imaging Reports ___Respiratory Therapy Notes
___History and Physical ___EKG Reports ___Nurses Notes
___Progress Note ___Physical Therapy Notes ___Medication List
___Laboratory Results ___Consultations ___Other (specify)____________

Treatment Covering: From: ____________ **To:** ____________

Release To: ____________________ **Address:** ____________________

For the purpose of: ____________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include infomation about behavioral or mental health services, and treatment for alcohol and drug abuse.

____Yes, I consent to the release of this information. ____No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:____________________

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact **CRMC Compliance Officer.**

____________________ ____________________
Signature of Patient or Legal Representative ***Date***

____________________ ____________________
Relationship to Patient (If Legal Representative) ***Witness***

**************COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT**************

I understand that my medical record my contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold **Childress Regional Medical Center** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____________________ ____________________
Signature of Patient or Legal Representative ***Date***

____________________ ____________________
Relationship to Patient (If Legal Representative) ***Witness***

Release of records is in accordance with the HIPAA [illegible]