AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

NAME OF PATIENT:		**PATIENT DATE OF BIRTH:**	
PHONE NUMBER:		**DATE(S) OF TREATMENT:**	

I, authorize Baylor Scott & White Medical Center- Frisco (Facility) to use or disclose the information specified below from the medical record of the above- named patient.

PATIENT INFORMATION IS NEEDED FOR : PLEASE SELECT ONE OPTION

☐ Continuing Medical Care ☐ Personal Use ☐ Legal Purposes

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical ☐ Discharge Summary ☐ Radiology Images ☐ Operative Reports ☐ ER Records

☐ Lab Reports ☐ Pathology Reports ☐ Radiology Reports ☐ Discharge Instructions ☐ Medication

☐ Billing Records ☐ Abstract (these documents generally used for continuing care)

☐ OTHER _____ (fees may be associated with requests for complete chart copies)

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via telephone at the number provide above when records are ready for pick up)

☐ Mail to Address listed below ☐ Fax to healthcare provider at: _____ ☐ CD (may take up to 3 business days)

☐ Email : _____
(email address)

_____
(Name)

_____
Address (Street, State, Zip Code) Phone Number

Your initials are required to release the following information:

_____ ***Psychotherapy notes****: Detailed notes kept by a mental health professional documenting or analyzing converstation during a private, group, or family counseling session(which receive extra protection distinct from general medical charts)*

_____ ***Mental health and psychiatric records:*** *Diagnoses, treatment plans, or history related to mental illness, psychiatric care, or developmental disabilities.*

_____ ***Substance use and abuse records:*** *Information regarding the diagnosis, referral, or treatment of alcohol or drug use under strict federal confidentiality rules(42 CFR part 2) (1,2,3)*

_____ ***HIV/AIDS status:*** *The fact that an HIV test was ordered, performed, or reported, along with related diagnoses or treatments. (1,2)*

_____ ***Sexually transmitted diseases (STDs) and reproductive health:*** *Lab results, diagnoses, or care related to STDs or sensitive reproductive health details. (1,2)*

_____ ***Genetic testing information:*** *Results of genetic tests, familial genetic markers, or related health predictions. (1,2)*

_____ ***Abuse, neglect, and assault records:*** *Information regarding child abuse and neglect, adult domestic abuse, or sexual assault>(1,2)*

I understand that information released under this authorization may be disclosed by the recipient. Baylor Medical Center Frisco is not liable for redisclosure. The records released may include information regarding medical history, treatment, examinations, hospitalization, HIV/AIDS-related testing, diagnosis or treatment, psychiatric care, and substance abuse treatment, if applicable. I release Baylor Medical Center Frisco, its physicians and employees from liability related to the release of these records.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization, by writing the Facility Privacy Officer at: 5601 Warren Parkway, Frisco, TX 75034.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize the Facility to use or disclose my health information in the manner described above.

Date: _____ **Signature:** _____
Patient or Legally Authorized Representative
(electronic signature not acceptable)

_____ _____
Relationship to Patient **Printed Name of Patient or Legally Authorized Representative**

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