MIDLAND MEMORIAL HOSPITAL – MIDLAND, TEXAS 79701

AUTHORIZATION TO RELEASE MEDICAL RECORDS

☐ **Midland Memorial Hospital** ☐ **Diagnostic Imaging Associates** ☐ **The Breast Center**

Patient Name_____ Date(s) of Service_____

Date of Birth_____ Social Security Number_____

I, the undersigned, authorize the release of information from the facility specified above from the medical record(s) of the above named patient.

The information is released to:_____
(physician, hospital, attorney, insurance company, self, etc.)

Address_____ City_____ State_____Zip_____

Phone # _____ Fax # _____

PATIENT INFORMATION IS NEEDED FOR:

☐ Attorney/Legal ☐ Continued Medical Care ☐ Insurance Company
☐ Personal Use ☐ Social Security/Disability ☐ Military
☐ Worker's Compensation ☐ Other_____

INFORMATION TO BE RELEASED:

☐ Emergency Room Record ☐ Progress Notes ☐ Lab Reports ☐ History and Physical
☐ Physician Orders ☐ Pathology Report ☐ Discharge Summary ☐ EKG, EEG, EMG
☐ Operative Reports ☐ Radiology Report ☐ Radiology Images
☐ Other_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer protected by the law.

Your initials are required to release the following information:
I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric (excluding psychotherapy notes) Reproductive Health Information, Genetic Information (including Genetic Test Results)HIV testing, HIV results, or AIDS information. * _____(Please Initial)

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. I understand that to revoke my authorization, I must send a written request to Midland Memorial Hospital, Attention: Privacy Officer, 400 Rosalind Redfern Grover Parkway, Midland, Texas 79701 or by fax (432-221-4670). I understand I may be charged a retrieval/ processing fee and for copies of my medical records according to Texas Hospital Licensing law.

I understand that Midland Memorial Hospital may not condition my treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization when the prohibition on the conditioning of authorizations set forth in 45 C.F.R. § 164.508(b)(4) applies. 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:_____

Date_____ Signature_____
(Patient or Legally Authorized Representative)
(Relationship to Patient)

Contact Phone Number _____ _____

E-Mail Address _____

MR#:_____

Description of Authority to act on behalf of patient (attach copy of any necessary legal documents):