

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

1. Release information from the hospital record of:

Patient's Name - Please Print

Date of Birth

Social Security Number

Date of Treatment (Month/Day/Year to Month/Day/Year)

Telephone Number

Work Telephone Number

2. I hereby authorize Green Oaks Hospital to release information to and/or obtain information from:

Doctor, Hospital, Insurance Company, Attorney, etc. to Receive Information

Fax Number

Address

Telephone Number

For the purpose of: _____

3. Information to be Released:

- | | | |
|---|--|---|
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> History and Physical | <input type="checkbox"/> PES Record |
| <input type="checkbox"/> Dates of Service | <input type="checkbox"/> Intake / Psychosocial Assessment | <input type="checkbox"/> Physician Discharge Summary |
| <input type="checkbox"/> Doctor's Orders | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Master Treatment Plan / Updates | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Entire Chart | <input type="checkbox"/> Nurse's Notes | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> PES Patient Instructions / Physician Discharge Order | <input type="checkbox"/> Verbal Communication With: _____ |
| | | <input type="checkbox"/> Other (Specify): _____ |

4. I understand that the specific information to be disclosed may include history of **Drug or Alcohol Abuse or Mental Health Treatment**, information concerning communicable diseases such as **Human Immunodeficiency Virus (HIV)**, and **Acquired Immune Deficiency Syndrome (AIDS)**, laboratory test results, treatment progress, and any other such related information.

5. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire 180 days from the date of my signature or condition as follows:

6. I further authorize that a photocopy of this authorization is acceptable as an original.

7. Once this information is disclosed to a third party it may be subject to re-disclosure by the recipient and may no longer be protected by this rule.

8. There may be a fee for copying medical records, the State of Texas has set these fees based on the costs for providing this service.

9. If you are claiming to be the patient's legal representative, you must indicate that authority and provide supporting documentation.

10. Your right to obtain or review your medical record may be limited if your physician determines access to your record will be harmful to your physical, mental, or emotional health.

X _____
Signature of Patient or Legal Representative

Date

Relationship to Patient

X _____
Witness Signature

If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

GREEN OAKS HOSPITAL
ATTN: MEDICAL RECORDS
7808 CLODUS FIELDS DR.
DALLAS, TX 75251

Phone # 972-770-0872

Fax #: 972-980-4015