I hereby authorize Uvalde Memorial Hospital to use and disclose protected health information from the record(s) of:

Name: _____ Social Security No.: XXX–XX–_____ Date of Birth: _____

Medical Record No.: _____ Date(s) of Service: _____ to _____

To Whom: _____

For the purpose of: Medical Care Insurance Litigation Other

I specifically authorize use and disclosure of the following records: (Please Check)							
History & Physical		Pathology		ER Visit		Complete Medical Record	
Discharge Summary		Laboratory		Admission Facesheet		Physician Orders	
Operative		Radiology Reports		Immunizations		Medications	
Consultation		EKG		PT / OT / ST		Other	

Permanent Transfer of Original Radiology Films

Radiology Original Films

I hereby Authorize Uvalde Memorial Hospital to permanently release / Transfer original Radiology Films for dates of service outlined above. Uvalde Memorial Hospital is hereby released from legal responsibility or liability for the safe keeping (storage) of said original film records. _____ (initials)

I understand that these records can include information about HIV / AIDS status, alcohol and substance abuse, and / or mental conditions. Uvalde Memorial Hospital is hereby released from legal responsibility or liability for the release of information to the extent authorized herein. This authorization extends to furnishing of copies of any / all parts of the record in order to comply with the request as stated above. _____ (initials)

I understand that copies of the Records indicated above will be:	
(circle one) Mailed to: Hand Carried:	Faxed to:
Name of Recipient: _____	Name of Recipient: _____
Name of Company: _____	Name of Company: _____
Address: _____	Fax Number: _____
City, State, Zipcode: _____	Confirmation Phone Number: _____
	Date of Release: _____
	No. of Pages: _____ Released by: _____

* I understand that to the extent any Recipient of this information , as Identified above, is not a 'covered entity' under Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy laws once it is disclosed to the recipient and , therefore, may be subject to re–disclosure by the Recipient.

* I understand that I may revoke this authorization in writing at any time except to the extent that Uvalde Memorial Hospital has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the designee of Health Information Services, 1025 Garner Field Road, Uvalde, Texas 78801 and / or fax to 830–278–2257, stating my intent to revoke this authorization.

* Unless otherwise revoked, I understand that this authorization is valid until the 180th day after the date it is signed unless it provides otherwise or unless it is revoked.

* I understand that completion of this authorization form is not a condition of treatment.

_____ _____

Signature of Patient or Legal Representative Date Printed Name of Patient or Legal Representative

_____

Witness Date

Uvalde Memorial Hospital
Consent for: Medical Record Release – UMH