OLNEY HAMILTON HOSPITAL

AUTHORIZATION TO RELEASE MEDICAL RECORDS

P.O. BOX 158/901 W. HAMILTON ST. OLNEY, TX 76374
PHONE: 940-564-5521 FAX: 940-564-3606

Please complete entire form and read carefully

*Patient Identification

I _____ Date of Birth: _____/_____/_____ SS#:_____/_____/_____
(Please Print)

*Information to Be Released – Covering the Periods of Health Care

Specify Date of Service: _____/_____/_____
Span of Service: _____/_____/_____To: _____/_____/_____

*Please check type of information to be released:

☐ Entire medical record	☐ Pathology report	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results/reports	☐ X-ray reports	☐ X-ray films / images
☐ Operative report	☐ Emergency room record	☐ Itemized bill

☐ Other, (specify) _____

*Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other, (specify) _____

*Person(s) Authorized to Receive Information

Name(s) or Facility_____
Address:_____Phone#: _____Fax#:_____

*Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐ **Yes** ☐ **No** _____ **Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: ☐ **Yes** ☐ **No** _____ **Initials**

*Time Limit & Right to Revoke Authorization

*Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the **Health Information Management Department at 901 W Hamilton St, Olney, Texas 76374** unless revoked, this authorization will expire **180** days from the date of signature.*

*Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by The Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from a any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

*MEDICAL RECORD COPY FEES

*A basic retrieval or processing fee of **$35.00** for the first 10 pages of records may be charged. Additional charges may apply, please refer to **HH Fee Schedule**. Fees are imposed to cover the cost of labor, supplies, postage and in accordance with **Texas Health and Safety Code 241.154 and Senate Bill 667.***

*Signature of Patient or Personal Representative Who May Request Disclosure

I understand that **Hamilton Hospital** may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Hamilton Hospital to use and disclose the protected health information specified above.**

Patient Signature: _____Date: _____

Authorized Representative: _____Date: _____

Relationship to Patient: _____

Identity of Requestor Verified via: ☐Photo ID (attach a copy) ☐ Matching Signature ☐Other_____

Verified/Witnessed by: _____Date: _____

Revised 9/2016 per HIPAA guidelines

OLNEY
HAMILTON HOSPITAL

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Please complete entire form and read carefully

IT IS THE LAW!!

***Must have valid identification to obtain medical records. This also applies to anyone who has authorization to obtain your medical records.**

***EXAMPLE**: Drivers License*

***A spouse/friend/family member and so on cannot obtain your medical records unless he/she has a medical power of attorney or has your written authorization as specified on this form and your written authorization is required for each request.**

EXAMPLE:

Person(s) Authorized to Receive Information

Name(s) or Facility *Sue Smith -Wife and Power of Attorney*
Address: *111 11th ST.* Phone#: *564-1111* Fax#:_____

***Only a parent or legal custodian of a minor is allowed to obtain minors medical records.**

EXAMPLE:

Authorized Representative: *Sue Smith* **Date:** *09/01/2016*
Relationship to Patient: *Mother*

***An authorization can only be completed for existing dates of service and not for future dates that do not yet exist and must be completed for each request.**

EXAMPLE:

Information to Be Released – Covering the Periods of Health Care

Specify Date of Service: *08 / 31 / 2016*
Span of Service: *08 / 01 / 2016 To: 08 / 31 / 2016*

***An authorization form is only complete and valid when witnessed or verified by Hamilton Hospital staff.**

EXAMPLE:

Identity of Requestor Verified via: X Photo ID (attach a copy) ☐ Matching Signature ☐Other_____
Verified/Witnessed by: *Minnie Mouse-Medical Records Dept.* *Date: 09/01/2016*

Revised 09/2016 per HIPAA Guidelines