



HILL COUNTRY MEMORIAL HOSPITAL
Health Information Management Dept.
 Post Office Box 830 / 1020 S. State Hwy 16
 Fredericksburg, Texas 78624
 The Hill Country's Hospital / hillcountrymemorial.org
 Ph: 830-997-1280 / Fx: 830-997-1261
 medicalrecords@hillcountrymemorial.org

MED RECORD NO.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM HCM HOSPITAL

I hereby authorize you to release *hospital* information from the medical record of:

PATIENT NAME	DATE OF BIRTH
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This information is to be released to:

Authorized Person's Name: _____

Please check one-

- I would like my records mailed
 - o Address: _____
 - o City: _____ State: _____ Zip: _____
- I would like my records emailed
 - o Email Address: _____

Date(s) of Service Requested: _____

INFORMATION TO BE RELEASED (please check what you authorized to be released)		
Discharge Summary	Operative Report	Emergency Record
History & Physical	Consultation	Outpatient Record
Pathology Report	Lab Report	X-ray Report / Image Disc
Rehabilitation Record	Physician Progress Notes	Physician Orders
Nurses Notes	Medication Record	Add Authorized Person To My Portal
EKG	Itemized Bill	Other, please specify:

PURPOSE OF DISCLOSURE	
Attorney/Legal	Continued Patient Care
Insurance	Personal Use
Worker's Compensation	Other:

It is understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. **I understand that records from other health care providers will not be released with this request, only hospital records.** I hereby waive my/his/her right to the privileges of confidentiality with respect to any HIV test result or mental health information or drug and alcohol information that may be contained in the medical record. The health care provider, its employees and officers and physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. A photocopy or facsimile of this authorization shall be deemed to have the same force and effect as the original. I further understand that I may revoke this consent in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance thereon. **This consent will expire 180 days (6 Months) after date of signature.** If the PHI is re- released or if the release is to a non-covered entity it will no longer be protected.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PATIENT/GUARDIAN (if required)	DATE
SIGNATURE OF WITNESS	DATE

