Cochran Memorial Hospital
201 East Grant Avenue
Morton, Texas 79346
Ph: (806) 266-5566
Fax: (806) 266-5564

Authorization to Release Confidential Information
Inpatient & Emergency Department Only

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. USE BLUE OR BLACK INK ONLY.
Records must be picked up in person. We will NOT provide records by email or by any other electronic means.
Return completed form to Cochran Memorial Hospital.

Patient Name (Last, First, Middle Initial)	Date of Request
Other Name(s) Used, if any	
Date of Birth	SS#
Address	
Home Phone Number #	Alternate Phone #
Email	

I hereby authorize Cochran Memorial Hospital to release information to the individual or entity listed below:

Name	
Address	
Phone #	Fax#

Information to be Released:

Date(s) of service to be released_____

☐ **All health information**

☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results

☐ Physician's Orders ☐ Patient Allergies ☐ Operation Reports ☐ Consultation Reports

☐ Progress Notes ☐ Discharge Summary ☐ Diagnostic Test Reports ☐ EKG/Cardiology Reports

☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images

☐ Other_____

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Purpose of Disclosure *(check all that apply)* ☐ Treatment/Continuing Care ☐ Billing or Claims ☐ School ☐ Legal ☐ Employment ☐ Personal Use ☐ Other *(specify)*_____

- This authorization has an expiration date of one year from the date of request.
- I understand that you will provide this information within 15 business days from the receipt of request and payment.
- I understand that a fee may be charged for preparing and furnishing this information in accordance with rulings set forth by the Texas State Board of Medical Examiners.
- I understand that I may revoke this authorization at any time by notifying Cochran Memorial Hospital in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal HIPPA privacy regulations.
- I understand the records requested will only be released to the person or entity named on this form.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services, and/or alcohol or substance abuse.
- I understand that under Texas law, Cochran Memorial Hospital may request proof that I am the legally authorized representative of the patient if I am requesting another person's confidential medical records before my request is fulfilled. Forms of proof may include but not be limited to: Medical Power of Attorney documents, court order for guardianship, proof of heirship, personal representative or proof of next of kin status, such as birth certificates.
- **Printing fee: first five (5) pages are free; all other pages are $0.10 per page.** An invoice will be mailed prior to records being sent.

I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

_____ _____
Patient or Patient's Legally Authorized Representative Signature **Date**

Printed name of patient or legally authorized representative_____

If representative, specify relationship ☐ Parent of Minor ☐ Guardian ☐ Other_____