Cochran Memorial Hospital
201 East Grant Avenue
Morton, Texas 79346
Ph: (806) 266-5566 ext. 217
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 can be picked up in person or sent by certified mail. We will NOT provide records by email or by any other electronic means.

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 requested 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.

Intentionally blank, proceed to Page 3

Page 3 must be completed before a Notary Public

Cochran Memorial Hospital
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Authorization to Release Confidential Information
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To be completed by patient or patient's legally authorized representative.

DO NOT SIGN THIS PAGE UNTIL YOU ARE IN FRONT OF A NOTARY PUBLIC!

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_____

To be completed by Notary

State of _____ County of _____

Before me, _____, on this day personally appeared

_____, known to me or proved to me on the

oath of or through (*description of identity card or other document)* _____,

to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed

the same for the purposes and consideration therein expressed.

Given under my hand and seal of office *(date)*_____.

_____

(Notary Seal) Notary Public's Signature

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Morton, Texas 79346
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Cochran Memorial Hospital and Clinic
EST. 1947

Instructions

- Include an email address, this is how we will send you the tracking number upon receipt of your payment.
- Include a valid phone number in case we need to contact you.
- Make sure the address provided on the form is correct, the address on Page 1 of this form is where we will mail your records to.
- Do not sign Page 3 until you are in front of the Notary Public.
- Records will be mailed by certified mail within fifteen (15) business pays of receipt of payment of invoice.

Mail this original signed form – copies of the signed form will not be accepted, along with a copy of your in-date driver's license, state id or passport to:

Cochran Memorial Hospital
ATTN: MARY MCKNIGHT
201 E Grant Avenue
Morton, TX 79346

If you have questions or need help please contact:

Mary McKnight
(806) 266-5566 ext. 217
mmcknight@cochranmemorial.com