El Campo Memorial Hospital
Mid Coast Medical Clinic

Authorization for Disclosure or Inspection Of Protected Health Information

Patient Name	Date of Birth	Social Security Number	MR#
Address			**Telephone Number**

I hereby authorize: ______________________________
Facility Name

To release information from the medical records of______________________________
Patient Name

To:______________________________
Name/Address of person/organization to which disclosure is to be made

Fax #______________________ Phone #______________________

For treatment dates:______________________________
Specify dates – this line **MUST BE** completed

For the following purpose: ☐Medical Care ☐Legal ☐Insurance ☐Other (detail below)

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Select Portions

☐Discharge Summary ☐Lab ☐Emergency Room ☐Imaging/Radiology ☐Nursing Notes ☐History and Physical ☐Cardiac Studies ☐MD Progress Notes ☐MD Orders ☐Face Sheet ☐Operative/Procedure Report ☐Itemized Bill	☐ Entire Record **INCLUDING** Mental Health and /or Alcohol and Drug AbuseTreatment, HIV Testing & Chemical Dependency. ☐ Entire Record **INCLUDING** Mental Health and /or Alcohol and Drug AbuseTreatment ☐ Entire Record **EXCLUDING** Mental Health and /or Alcohol and Drug AbuseTreatment ☐ Entire Record **INCLUDING** HIV Testing & Chemical Dependency ☐ Entire Record **EXCLUDING** HIV Testing & Chemical Dependency ☐ Entire Record **INCLUDING** HIV Testing Only ☐ Entire Record **INCLUDING** Chemical Dependency Only ☐ Other______________________________

This authorization expires 180 days from the date signed below and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of the above named entity to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I also understand that treatment, payment, enrollment or eligibility may not be conditioned upon obtaining this authorization. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

____________	______________________________	____________________
Date	**Signature of Patient/Parent/Conservator/Guardian**	**Authority/Relationship to Patient**
____________	______________________________	
Date	**Witness**	

Fees/Charges will comply with all laws and regulations applicable to release of Protected Health Information.