Arise. | AUSTIN MEDICAL CENTER

An Affiliate of SCA

3003 Bee Caves Rd. Austin, TX 78746

AUTHORIZATION TO RELEASE MEDICAL INFROMATION

I authorize the Arise Austin Medical Center to release/obtain (circle one) medical information concerning:

Patient Name _____ Date of Birth:_____ Soc. Sec No. _____

Address _____ Dates of Service_____

City/State _____ ZIP _____ PH _____

This information is to be released to/obtained from (circle one):

Name _____

Address _____

City/State_____ ZIP _____ PH _____

Copy Requested: ☐ **Yes** ☐ **No**

Copy Requested: ☐ **Yes** ☐ **No**

Please release the following information, indicated by an "X":

☐ History & Physical	☐ Consultation	☐ Physician
☐ Laboratory	☐ Operative Report(s)	☐ EKG,EEG Records
☐ Discharge Summary	☐ Outpatient Record(s)	☐ Radiology /Film
☐ ER Records	☐ Progress Notes	☐ Other

I give special permission to release any information regarding items listed below **INITAL**

☐ HIV Medical Information	_____
☐ Psychiatric	_____
☐ Substance Abuse Records	_____

This information is necessary for the following purpose:

Follow up care Patient is requesting disclosure Disability Benefits ***Attorney***

Other** Please Explain _____ **Indicates Fee For Service

Will financial/compensation result in use or disclosure? ☐ **Yes** ☐ **No**

Please release my information via: ☐ Mail ☐ Orally ☐ Pick Up ☐ Fax (emergency only) _____

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire six (6) months from when it is signed unless otherwise specified (otherwise specified date_____). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, the Arise Austin Medical Center (AAMC) can no longer use or disclose my information for the above purposes without a new authorizations. All revocations will be sent to the attention of the AAMC Privacy Officer and become effective once received.

I understand the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I can get a copy of this form after I sign it.

FOR OFFICE USE ONLY:

☐ **Authorization added to the patient's medical record on** _____

☐ **Authorization verified by** _____ **on** _____

☐ **Patient has been provided with a copy of the signed authorization**

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulation 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

_____ _____ _____

Signature of Patient or Authorized Party **Date** **Relationship to Patient**

Witness_____ **REASON Patient is not Signing** _____