MILLWOOD HOSPITAL
& THE EXCEL CENTERS
Arlington • Fort Worth • Lewisville • Willow Park

PATIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby freely and voluntarily authorize Millwood Hospital and/or The Excel Center(s) to release/disclose records of my health information to:

_____ _____
Individual, Facility, Organization Phone Number

_____ _____
Address Fax Number

_____ ____ _____ _____
City State Zip Code

The purpose for this disclosure is: _____ to assist with funding _____to assist with medical treatment planning

_____to assist with education placement _____to coordinate discharge planning ____for legal purposes

_____other (specify) _____

Information to be released includes:

____Discharge Summary
____Admission Psychiatric Evaluation
____History and Physical
____Psychological Evaluation
____Educational Records/Assessment
____Other _____

____Treatment Plans
____Lab, X-Rays, EEG, EKG
____Verbal exchange of information
____Psychosocial History
____Integrated Progress Note

My medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable disease. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that I have the right to revoke this authorization at any time by giving written notice to Millwood Hospital and/or The Excel Center's Privacy Officer, except to the extent that Millwood Hospital and/or The Excel Centers has already taken action in reliance on this authorization. This authorization will expire in 180 days following discharge, from the date below, or sooner if otherwise specified herein: _____.

_____ _____ _____
Printed Name Patient Signature Date

Patient must sign release regardless of age, IF alcohol and/or drug treatment is involved

_____ _____ _____
Parent Printed Name Parent Signature Date

Parent/Guardian/Authorized Representative (describe: _____)

**Drug/Alcohol records are protected by federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by law. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*