Patient Name:____ **Birth Date:**_______/_____/______

Maiden/Prior Names:____ **Current Phone #:** ____________________

Current Address:____

I am requesting disclosure of my protected health information for the following purpose:

- ☐ Continuing Care
- ☐ Academic
- ☐ Disability Determination
- ☐ Legal Investigation
- ☐ Child Custody
- ☐ Other:_____________________

Dates of Service Requested:________________________

I authorize the release of the following:

☐ **Continuity of Care Packet** – (Discharge Plan Parts 1 and 2, Discharge Safety Plan, Medication Reconciliation, Discharge Summary, Psychiatric Evaluation, History & Physical, MAR, Labs)

☐ **Entire Record (Fee associated with this request)**

☐ **Verbal Exchange of Information ONLY**

To be released by:

MILLWOOD HOSPITAL____________ (817) 261-3121__________ARLINGTON_______TX_______________76011______

Agency/Name Telephone Number City State Zip Code

To be released to:

☐ ______________________ ____

Agency/Name Address City State Zip Code

(____)________________________ (______)____________________

Phone Number Fax Number

Name of School (if student)_____________________________**City**________________________**St**__________**Zip**______________

Counselor's Name____**Phone**_______________________

This authorization will expire on ____/____/**20**____**.** (If not indicated, authorization will expire six months from signature date)

This form must be completed in full before signing:

____________________________________ _____/____/_____ _____:_____

Patient's signature Date Signed Time

____________________________________ _____/____/_____ _____:_____

Legal Guardian Signature Date Signed Time

____________________________________ _____/____/_____ _____:_____

Witness signature/Credentials Date Signed Time

This authorization is intended to allow Millwood Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations. You have the right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization.

____ _____/___/____ ______:_____

Revocation Signature Date Time

Release of Information	Pt Label