

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Maiden/Prior Names: \_\_\_\_\_ Current Phone #: \_\_\_\_\_  
 Current Address: \_\_\_\_\_ Last 4 of SS#: \_\_\_\_\_

**To be released to:**

Self (address above)  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Name / Attention to Fax Number City State Zip Code

**To be requested from (optional):**

MILLWOOD HOSPITAL (817) 261-3121 1011 N. COOPER ST ARLINGTON, TX 76011  
 Agency/Organization Telephone Number Street Address

**Send Records Via (only when released to):**  Mail  Fax(specific request only)  Pick-up  Verbal Exchange of Information ONLY

Email: \_\_\_\_\_ \*\*\*\*REQUIRED\*\*\*\*

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

- Continuing Care  Disability Determination  Child Custody  Personal Use  
 Academic  Legal Investigation  Billing/Insurance  Other: \_\_\_\_\_

**Dates of Service Requested:** \_\_\_\_\_

**Please check one of the following:**

- I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, or  
 I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records,

**Only the information and records indicated below (check all that apply and /or specific if "Other is checked):**

- Continuity/Transition of Care Packet  Lab/Diagnostic Reports  
 Psychiatric Evaluation  HIV Test Results and AIDS Treatment Records  
 History and Physical  Other: \_\_\_\_\_  
 Discharge Summary  FULL RECORD ( FEE = \$27.10 PER ADMISSON)  
 Progress Notes  
 Physician Orders

This authorization will expire on \_\_\_/\_\_\_/20\_\_\_. (If not indicated, authorization will expire one year from signature date)

**This form must be completed in full before signing:**

\_\_\_\_\_  
 Patient's signature (required for ages 18 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

\_\_\_\_\_  
 Witness signature/Credentials ( if applicable) Date Signed

**HOW TO REVOKE AN AUTHORIZATION ( DO NOT SIGN BELOW UNLESS YOU WANT TO REVOKE AN AUTHORIZATION )**

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 redisclosure by the recipient and may no longer be protected by federal regulations. Your 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. A fee may be associated with the copying of my information in the processing of this request.

\_\_\_\_\_  
 Revocation Signature Date/Time