AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Baylor All Saints Medical Center to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name _____

Date of Birth ____ ____ / ____ ____ / ____ ____ ____ ____ (MM MM / DD DD / YY YY YY YY) Social Security Number ___ ___ ___ - ___ ___ - ____

Patient Address _____ Phone Number (_____) _____- _____

Date(s) of Service (if known) _____

Description of information to be released: (Check ✓ all that apply)

___ Emergency Room
___ History & Physical
___ Nurse's Notes
___ Progress Notes
___ Discharge Summary
___ Radiology Reports
___ Consultation Reports
___ Physician's Orders
___ Operative Records
___ Radiology Films
___ Admission/Registration Records
___ Laboratory Reports
___ Billing Records
___ Other: _____

Description of the purpose of the use and / or disclosure: _____

_____

The health information described herein shall be released to: (Check ✓ the appropriate category)

___ Hospital ____ Physician ____ Insurance Company _____ Attorney ____ Patient _____ Other

Name _____

Address _____

Phone Number _____

Fax Number _____

(Check ✓ the appropriate delivery method)

___ Mail
___ Fax
___ Pick-up Records
___ Other _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date / event).

I further understand that I may revoke this authorization at any time by notifying Baylor All Saints Medical Center in writing at 1400 Eighth Ave., Fort Worth, TX 76104. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (attach supporting documentation)

MED REC NO. _____

PATIENT _____

PHYSICIAN _____

BILLING NO. _____

BAYLOR ALL SAINTS MEDICAL CENTER
FORT WORTH, TEXAS

AS-46008 (Rev. 7/04)

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