Childress Regional Medical Center
PO Box 1030, 901 Hwy 83 North
Childress, TX 79201

Phone 940-937-6371
Fax 940-937-9146

AUTHORIZATION FOR RELEASE OF INFORMATION

(Photocopies of this consent in its original form shall be acceptable)

Date of Request: _____ Patient Name: _____ DOB: _____

I hereby authorize Childress Regional Medical Center to release information related to the treatment of the above referenced patient.

Information to be released: (check all that apply)

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Progress Notes
- ☐ Consultation Notes
- ☐ X-ray and Imaging Reports
- ☐ EKG Reports
- ☐ Medication List
- ☐ Laboratory Results
- ☐ Respiratory Therapy Notes
- ☐ Nurse Notes
- ☐ Physical Therapy Notes
- ☐ Other:

Treatment Dates: _____ To: _____

Purpose of Release: _____

Release Records to: _____

Mailing Address or Email*:_____

Fax and Phone Number: _____ _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavorial or mental health services, and treatment for alcohol and drug abuse.

____ Yes, I consent to the release of this information. ____ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. *If I provide an email address, I understand and give express permission to send records using this method in a secure email transmission.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides any insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, even or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to sure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact CRMC Compliance Officer.

_____ _____

Signature of Patient or Legal Representative / Date Witness / Date

_____

Relationship to Patient

****************************COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT****************************

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____ _____

Signature of Patient or Legal Representative/Date Relationship to Patient Witness / Date