PRINT SAVE AS EMAIL RESET

Baylor Scott & White HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BSWH)

I hereby authorize:

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

to disclose my individually identifiable health information as described below. I understand the following:

- This Authorization is voluntary and I may refuse to sign this document.
- My health care and the payment of my health care will not be affected if I do not sign this form.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization at any time by notifying the disclosing individual/organization listed above in writing. This 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.
- This authorization will expire in 180 days or at the date or event specified here: _____

Patient Name	Date of Birth	Acct #	MRN
Street	City	State	Zip
Telephone number	Email:		

The information will be released TO:

Individual/Organization Name: **Baylor Scott & White Health**		Telephone Number	
Street Address	City	State	Zip
Fax number	Email		

Purpose: Continued Care

Record copy delivery: ☐ Fax to healthcare provider/facility ☐ Mail ☐ Email ☐ Other _____

Please release the following information for treatment dates: from _____ to _____

Include this information if applicable: _____ Alcohol/Drug _____ Genetics _____ HIV/AIDS _____ Mental Health
(PT INITIALS) (PT INITIALS) (PT INITIALS) (PT INITIALS)

☐ Summary Abstract only (clinic notes, history & physical, procedure reports, pathology, consultations, test results, discharge summary)

☐ Clinic Notes	☐ Consultations	☐ Laboratory	☐ Radiology Images (CD only)
☐ Emergency Department	☐ Discharge Summary	☐ Medication	☐ Radiology Reports
☐ Billing Record	☐ History & Physical	☐ Operative Reports	
☐ Complete Chart	☐ Immunization	☐ Progress Notes	

☐ Other: _____

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Information request. I consider this as my electronic signature for this request.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

_____
Representative's Authority to Act for Patient (attach supporting documentation)

Scan doc type: Authorization to Release Protected Health Information

BAYLOR SCOTT & WHITE HEALTH