TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
2222 WELBORN STREET
DALLAS, TX 75219

Patient Name:

Date of Birth:

TSRHC #:

Current phone #:

Authorization To Disclose Health Information

I authorize the use or disclosure of the above named individual's health information as described below:

1. Texas Scottish Rite Hospital for Children is authorized to make the disclosure to the following individual or organization: *(Please provide complete name, address and phone number)*

   Name: Legacy Scholarship Program

   Address: 2222 Welborn Street

   Dallas, Texas 75219 Phone: _____

2. For the Purpose of: confirming patient status, physician and diagnosis

3. The type and amount of information to be used or disclosed: *(please include dates where appropriate)*

- ❑ Diagnosis/Procedures listing
- ❑ Medication list
- ❑ List of allergies
- ❑ Immunization record
- ❑ Most recent history and physical exam report
- ❑ Most recent clinic visit report
- ❑ Most recent discharge summary report
- ❑ Laboratory reports dated _____ to _____
- ❑ X−ray reports dated _____ to _____
- ❑ X−ray film dated: _____ type: _____
- ❑ Consultation reports form Dr. _____
- ❑ Psychological reports dated _____ to _____
- ❑ Genetics reports dated _____ to _____
- ❑ Copy of entire health record
- ☒ Other (Specify) see purpose

4. I understand that the information in my (my child's) 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 behavioral or mental health services, alcohol or drug abuse, and/or social and family related matters.
5. I understand that this authorization will remain in effect for 1 year from the date signed. I further understand that I may revoke this authorization at any time by notifying the Medical Records Department in writing at 2222 Welborn Street, Dallas, Texas 75219. I understand that the revocation will not apply to information that has already been released in response to this authorization.
6. I understand that authorizing the disclosure of this health information is voluntary and that my (my child's) health care treatment and eligibility for benefits will not be affected if I do not sign this form.
7. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may no longer be protected by federal and state privacy laws.
8. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosures of my health information, I can contact the Medical Record Department at Texas Scottish Rites Hospital for Children.
9. I understand and authorize that information may be disclosed electronically pursuant to this authorization.

Signature Relationship to Patient Date

Original to chart; Copy to Patient