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

Patient name:

Date of birth:

TSRHC #:

Current phone number:

Authorization to Disclose Health Information

I authorize Texas Scottish Rite Hospital for Children to disclose treatment/medical information about the patient listed above with the individual listed below:

Texas Scottish Rite Hospital for Children is authorized to make the disclosure to the following individual or organization: **(*Please provide complete name, address, phone number and FAX number of where you wish your records to be sent.)***

Contact:
Name (Nombre)_____ Street Address (Direccion)_____

City (Ciudad)_____ State (Estado) ____ Zip Code (Zona Postal)_____

Phone (Teléfono cellular) _____ FAX _____

For the Purpose of: *(personal records, continuity of care, school, military, etc.)*

The type and amount of information to be disclosed: *(Please include dates where appropriate)*

- ☐ Copy of entire health record
- ☐ Diagnosis & Procedure List / Coding Summary
- ☐ Most recent history and physical exam report
- ☐ Most recent clinic visit report
- ☐ Most recent operative summary
- ☐ Discharge summary report
- ☐ Laboratory reports dated_____ to _____
- ☐ X−ray reports dated_____to _____
- ☐ X−ray CD dated_____to _____
- ☐ Genetics reports dated _____
- ☐ Psychological reports dated _____to _____
- ☐ Other *(be specific)* _____

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.

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 Health Information Management 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.

I understand that authorizing the disclosure of this health information is voluntary and that my (my child's) health care treatment eligibility for benefits will ot be affected if I do not sign this form.

I understand that any disclosure of information carries with it the potential for an unauthorized re−disclosure and the information may no longer be protected by federal and state privacy laws.

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 Health Information Management Department at Texas Scottish Rite Hospital for Children.

I understand and authorize that information may be disclosed electronically pursuant to this authorization.

He recibido y revisado la versi?n en español de este consentimiento.
(I have received and reviewed a Spanish−language version of this authorization form.)

_____

Signature Relationship to Patient ☐ Legal Guardian Date