

Date Request Completed/Faxed:  
 Total Pages Released:  
 Request Completed By:

**Section A: This section must be completed for all Authorizations (Texas)**

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Patient's Phone Number:</b>	<b>Last Four Digits SSN (optional):</b>
<b>Provider's Name:</b> Medical City Dallas Hospital	<b>Recipient's Name:</b>		
<b>Provider's Address:</b> 7777 Forest Lane Dallas, Texas 75230	<b>Address 1:</b>		<b>Recipient's Phone:</b>
	<b>Address 2:</b>		
	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

**Request Delivery (If left blank, a paper copy will be provided):**  Paper Copy  Electronic Media, if available (e.g., USB drive, CD/DVD, eDelivery)  
 Encrypted Email  Unencrypted Email  
**NOTE:** In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

**Email Address (If email checked above please print legibly):** \_\_\_\_\_

Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed: (Fill in the Date or the Event but not both.)  
**Date:** \_\_\_\_\_ **Event:** \_\_\_\_\_

**Purpose of disclosure:** \_\_\_\_\_

**Description of information to be used or disclosed**

Is this request for psychotherapy notes?  Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.  No, then you may check as many items below as you need.

<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical test <input type="checkbox"/> Medication sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Nursing information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER information		<input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-04: <input type="checkbox"/> ECT OR Psych. Info. <input type="checkbox"/> Other:	

I hereby authorize the Hospital marked below to release records to the recipient party designated above.  
**DFW Sites:**  
 Denton Regional Medical Center  Las Colinas Medical Center  Medical Center of Plano  Medical City Dallas  
 Green Oaks Hospital  Medical Center of Lewisville  North Hills Hospital  Medical Center Alliance  
 Medical Center Arlington  Medical Center of McKinney/Wysong  Plaza Medical Center  Medical City Frisco

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ (Initial)  
 If this authorization is for disclosure of genetic information, please describe: \_\_\_\_\_

I understand that:  
 1. I may refuse to sign this authorization and that it is strictly voluntary.  
 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.  
 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.  
 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.  
 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.  
 6. I get a copy of this form after I sign it.

**Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?**  Yes  No  
 If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information?  Yes  No  
 If yes, describe: \_\_\_\_\_


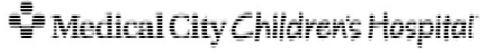
May the recipient of the PHI further exchange the information for financial remuneration?  Yes  No

**Section C: Signatures**

I have read the above and authorize the disclosure of the protected health information as stated.

**Signature of Patient/Patient's Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name of Patient's Representative:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

 **Medical City**  **Medical City Children's Hospital**  
 7777 Forest Lane • Dallas, Texas 75230 • Phone: 1-888-749-7952  
 Fax: 469-484-2006  
**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**

PATIENT IDENTIFICATION

