

MIDLAND MEMORIAL HOSPITAL – MIDLAND, TEXAS 79701

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Midland Memorial Hospital Diagnostic Imaging Associates The Breast Center

Patient Name _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of information from the facility specified above from the medical record(s) of the above named patient.

The information is released to: _____
(physician, hospital, attorney, insurance company, self, etc.)

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

PATIENT INFORMATION IS NEEDED FOR:

- Attorney/Legal Continued Medical Care Insurance Company
 Personal Use Social Security/Disability Military
 Worker's Compensation Other _____

INFORMATION TO BE RELEASED:

- Emergency Room Record Progress Notes Lab Reports History and Physical
 Physician Orders Pathology Report Discharge Summary EKG, EEG, EMG
 Operative Reports Radiology Report Radiology Images
 Other _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the law. I understand that the specified information to be released may include, but is not limited to, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand that to revoke my authorization, I must send a written request to Midland Memorial Hospital, Attention: Privacy Officer, 400 Rosalind Redfern Grover Parkway, Midland, Texas 79701 or by fax (432-221-4670). I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

I understand that Midland Memorial Hospital may not condition my treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization when the prohibition on the conditioning of authorizations set forth in 45 C.F.R. § 164.508(b)(4) applies. This authorization will expire one hundred eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____

Date _____ Signature _____ (Patient or Legally Authorized Representative)

Contact Phone Number _____ (Relationship to Patient)

E-Mail Address _____

MR#: _____

Description of Authority to act on behalf of patient (attach copy of any necessary legal documents): _____