Valley Baptist Health System

1ROI

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Phone Number: 956-389-1713 **Fax**: 956-389-1714

SELECT METHOD OF DELIVERY:

MAIL: _____ PICK-UP: _____ FAXED: _____ EMAIL: _____ ELECTRONIC: _____

Patient Name: _____ Date of Birth: _____

Account #: _____ Telephone Number: _____

Date(s) of Hospital Service: _____

Current Address: _____ Email Address: _____

PLEASE RELEASE THE FOLLOWING INFORMATION:

☐ Admission Face Sheet	☐ History and Physical	☐ Discharge Summary	☐ Consultation Report
☐ Physician Orders	☐ Progress Notes	☐ Medication Record	☐ Emergency Department Record
☐ Lab Results	☐ Treatment / Diagnosis	☐ Respiratory Treatment Notes	☐ Rehab (PT/OT/ST) Record
☐ Operative Report	☐ Pathology Reports	☐ Cardiology Reports	☐ Cardiology Film / CD
☐ Radiology Reports	☐ Radiology Film / CD	☐ HIV / AIDS Testing	☐ Mental Health Information

☐ Billing Records / Financial Information ☐ Other, please specify: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and / or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV / AIDS – related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

I HEREBY AUTHORIZE:

☐ Valley Baptist Medical Center, Harlingen TX ☐ Valley Baptist Medical Center, Brownsville TX ☐ Valley Baptist Micro Hospital, Weslaco TX

☐ RECIPIENT: Name of person or class of persons to whom Valley Baptist Health System may disclose my health information:

_____

☐ Address of the recipient or where my health information should be delivered:

_____
STREET CITY STATE ZIP CODE

TERM: This Authorization will remain in effect (if left blank below, this Authorization will remain in effect for 365 days or one year):

☐ From the date of this Authorization until the _____ day of _____, 20_____.
☐ Until Valley Baptist Health System fulfills this request.
☐ Until the following event occurs: _____
☐ Other: _____

PURPOSE: I Authorize Valley Baptist Health System to use or disclose my health information (including highly confidential information (selected above, if any) during the term of this Authorization for the following specific purpose(s):

[Note: *at the request of the Patient* is sufficient if the patient is initiating this Authorization]:

☐ The Disclosure is at my (patient's) request	☐ Disability Determination	☐ Attorney / Legal Investigation	☐ Personal Use
☐ Further Medical Care	☐ Government Agency / Policy	☐ View Medical Records on site	☐ Insurance

I understand that Valley Baptist Health System may charge me a per page fee for copying services necessary to complete my request.

_____ _____
Signature of Patient or Patient's Representative Date Time

_____ _____
Name of Representative (if applicable) Description of Representative

_____ _____
Name of Witness / Translator (if applicable) Date Time

RELEASE OF INFORMATION

«PatientNumber»