

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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Admission Face Sheet | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Emergency Department Record |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Treatment / Diagnosis | <input type="checkbox"/> Respiratory Treatment Notes | <input type="checkbox"/> Rehab (PT/OT/ST) Record |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Cardiology Reports | <input type="checkbox"/> Cardiology Film / CD |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Radiology Film / CD | <input type="checkbox"/> HIV / AIDS Testing | <input type="checkbox"/> Mental Health Information |
| <input type="checkbox"/> Billing Records / Financial Information | <input type="checkbox"/> 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 intellectual disabilities
- 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]:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> The Disclosure is at my (patient's) request | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Attorney / Legal Investigation | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Government Agency / Policy | <input type="checkbox"/> View Medical Records on site | <input type="checkbox"/> 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