Please complete, sign, and return with a copy of ID with signature.

Health Information Services
1900 Pine
Abilene, Texas 79601-2432
Phone (325) 670-2407/6505
Fax (325) 670-6503/6558

HENDRICK HEALTH SYSTEM

Business Hours:
Monday – Friday
8:00 AM - 4:30 PM
Closed holidays

WRITTEN AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(HIPAA COMPLIANT RELEASE)

I hereby authorize **HENDRICK MEDICAL CENTER, 1900 Pine, Abilene, Taylor County, Texas**, to disclose and/or produce true and correct copies of the health care information (including any and all individually identifiable health information under HIPAA regulations) identified below pertaining to the history, diagnosis, treatment or prognosis of:

Patient
Name:_____ **Date of Birth**: _____ **SSN**: _____

Treatment date: _____ **Release Information Via**: ☐ *mail* ☐ *pick-up*
☐ *electronic* ☐ *fax* ☐ *verbal communication*

Please release the CIRCLED information only*:

Insurance package	Hearing screening	Operative Reports
Complete package	History/Physical	Physician orders
Consultation report	Immunizations	Radiology (X-ray, CT scan, MRI)
Discharge summary	Lab reports	Rehab (Speech/Hearing/Occupational)
EKG, EEG, EMG	Medication records	Trauma center (ER)
Face sheet	Other _____	

** Please note that the health information released may include information obtained from other treating facilities or provider.*

This information is to be released to:
Name:_____ **Phone number:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

This information is necessary for the following purpose:
☐ SSI/disability ☐ Follow-up care ☐ Insurance ☐ Personal use ☐ Attorney
☐ Other, please expain_____

Notice to Patient or Patient's Representative

(1) I understand that this may include information concerning fertility treatment, STD treatment, communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), any mental illness (except for psychotherapy notes), chemical or alcohol dependency, lab results, medical history, treatment, or any other related information.
(2) I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I have the right to revoke this authorization in writing.
(3) I understand that this authorization will expire upon completion of this request or after 180 days, whichever occurs first; or at the date or event specified here: _____.
(4) I understand that health care or payment for health care will not be affected if I do not sign this authorization.
(5) I understand the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and that it may no longer be protected by HIPAA privacy regulations.

_____ _____ _____
Signature of Patient or Legal Representative | Date | Representative's authority to act for patient

Released by: _____ Pager/Ext: _____ Date: _____
Upon receipt of a complete request, copies of the requested information will be made within 15 days.