RELEASE OF INFORMATION

I hereby authorize the following information to be released from the medical record of:

Patient Name:_____ DOB:_____

Address:_____ City/State/Zip:_____

Phone#_____ Social Security#_____

This information is to be released

TO:_____

_____

_____

_____

FROM: Coryell Health Medical Clinic

1507 W. Main St.

Gatesville, TX 76528

Telephone: (254) 865-2166 Fax: (254) 248-0626

PLEASE CHECK INFORMATION TO BE RELEASED

Treatment Date:_____

HOSPITAL RECORDS

- Progress Notes
- Nursing Notes
- Discharge Planning
- Medication Records
- History & Physical
- Discharge Summary

CLINIC RECORDS

- Clinic Notes
- Ophthalmology
- Dentistry
- Emergency Room

OTHER RECORDS

- Lab Report
- EKG, EEG, EMG
- X-Ray Report
- X-Ray Film
- Mammogram Report
- Mammogram Film
- Operative Report
- Pathology Report
- Immunizations
- Billing
- Directive to Physician
- Physician's Orders

Other:_____

Including information (if applicable) pertaining to:

Psychiatry/Psychology Drug Alcohol HIV/AIDS Genetic

Purpose of Disclosure:

- Attorney/Legal
- Continued Patient Care
- Person Use (at the request of the individual)
- Commercial Insurance
- Worker's Compensation
- Review Medical Records Only

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" Federal or Texas Privacy law, this information may no longer be protected by Federal and Texas Privacy law is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that CH already relied on this authorization. I understand that I may revoke this authorization by providing CH Release of Information Department a written request for revocation stating my intent to revoke this authorization.

I understand that CH may not condition treatment on any completion of this authorization form.

PATIENT/AUTHORIZED SIGNATURE	DATE	RELATION TO PATIENT