MISSION REGIONAL MEDICAL CENTER
900 SOUTH BRYAN ROAD
MISSION, TEXAS 78572

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record Number: _____

Social Security Number: _____ D.O.B.: _____

I authorize **MISSION REGIONAL MEDICAL CENTER** to disclose information relating to the above named individual's health information. The type and amount of information to be used or disclosed is listed below:

Check Appropriate Document	*List Dates Below*
_____ Operative Report	_____
_____ History & Physical	_____
_____ Discharge Summary	_____
_____ Laboratory Results	_____
_____ Radiology Results	_____
_____ Pathology Report	_____
_____ EKG Reports	_____
_____ Emergency Room	_____
_____ Entire Record (Excluding Fetal Monitoring Strips)	_____
_____ Fetal Monitoring Strips	_____
_____ Other: _____	

Please check the purpose for which the requested information is needed:

☐ **Continuation of care** ☐ **Personal** ☐ **Attorney** ☐ **Medicaid/Medicare**
☐ **Insurance** ☐ **Disability** ☐ **Other:**

1. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavorial or mental health services, and treatment for alcohol and drug abuse.
2. **This information may be disclosed to and used by the following individual or organization:**
   Name of Person/Organization: _____
   Address: _____
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIM/Medical Records Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify a date, this authorization will expire six months (Tex. H&S § 166.155).
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for any unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Date