AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Medical Record Department Phone #: 254-562-0408 EXT: 1421/1230

Parkview Regional Hospital Fax #: 254-562-6851
600 S. Bonham
Mexia, Texas 76667

I, the undersigned, hereby authorize Parkview Regional Hospital to release information specified below from the medical record of:

Patient Name: _____

DOB: _____

SS: _____

Hospitalization (Dates): _____

Reason for Release of Information is (please be specific): _____

Article 4495B, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include the "reasons or purposes for the release".

Information to be released:

__ Copy of entire medical records __ History and Physical

__Discharge Summary __Operative Report

__Drug and Alcohol records __Psychiatric/mental health records

__Other (Specify) _____

Please release above information to: _____
_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided for by law. I also understand that I may revoke this authorization at any time except to the extent that action has been taken to reliance on it and that in any event this authorization expires automatically as described below.

This authorization expires in ninety (90) days from the date of my signature unless otherwise specified by date, event or condition as follows: _____.

_____ _____
Patient or Legal Representative Date

_____ _____
Relationship to Patient Witnessed By