



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Baylor Scott & White Health to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 180 days from the date of signature or at the date or event specified here _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, the Baylor Scott & White Health facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another health care provider. ☐ I would like to review my record

Patient Name	Last 4 of Social Security Number	Date of Birth MM / DD / YYYY	Acct #	MRN
Street Address		City, State, Zip	Telephone Number	

Please release information from these BSWH facilities: _____

Please release the following information for these treatment dates: _____

The information will be released to: ☐ Patient/Designee ☐ Health Care Entity ☐ Insurance Company ☐ Attorney
☐ Other

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other _____

Record copy format: ☐ Paper ☐ CD ☐ _____ **Record copy delivery:** ☐ Pick-up ☐ Mail ☐ Fax to healthcare office
☐ MyBSWHealth ☐ Email _____

Information to be released:

Include this information if applicable: _____ Alcohol/Drug _____ Genetics _____ HIV/AIDS _____ Mental Health
PT INITIALS PT INITIALS PT INITIALS PT INITIALS

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Summary Abstract only (clinic notes, history/physical, procedure reports, pathology, consultations, test results, discharge summary) | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication | <input type="checkbox"/> Provider Orders |
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> History/Physical | <input type="checkbox"/> Nurses' Notes | <input type="checkbox"/> Radiology Film |
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Immunization | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Complete Chart (Fee) | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Progress Notes | |
| <input type="checkbox"/> Consultations | | | |
| <input type="checkbox"/> Other: _____ | | | |

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Information request. I consider this as my electronic signature for this request.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Relationship to Patient

Representative's Authority to Act for Patient
(attach supporting documentation)

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