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

Address: _____ **Phone Number**_____

E-Mail:_____

I hereby authorize:

El Paso County Hospital District (EPCHD) d/b/a University Medical Center of El Paso, Medical Record Dept., **4815 Alameda Ave, El Paso, TX 79905** **Phone (915) 521-7690 FAX (915) 521-7591**	**or**	**Radiology, Clinics, Patient Financial Service**

_____**(Recipient Name)**

Release Medical Record Information from/to Outside Healthcare facility /Physician/Office/patient/other:

_____

Address, City, State, Zip

Phone # _____**Fax #**_____ **Dates of Treatment**_____

Access Type Requested

❒ Copies of record

❒ Inspection of record

Information to Release

❒ Abstract/Pertinent
❒ Cardiac Studies
❒ Consult
❒ Emergency Room
❒ H&P
❒ Lab
❒ Operation Report
❒ Rehab
❒ Radiology Report

❒ Instructions at Discharge
❒ Discharge Summary
❒ Problem List
❒ Medication Record
❒ Medication Allergies
❒ Diagnostic Test Results
❒ Procedures

❒ Other _____

❒ Radiology Images /CD- Submit this authorization to Radiology
Phone (915) 521-7793
Fax (915) 521-7773

❒ Itemized Statement submit this authorization to Patient Financial Services
Phone (915) 521-7900
Fax (915) 521-1920

Purpose: ❒ Medical Care ❒Personal Use ❒ Attorney/Legal ❒ Other: _____

Preferred Receipt Method: ❒In-Person ❒Mail ❒E-mail ❒ Other: _____

_____ (initials) I acknowledge and consent that the released information may contain alcohol, drug abuse, psychiatric, HIV/AIDS information. Information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and no longer protected.

This authorization will expire 180 days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by the following date: _____. _____ initials.

I understand this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. To revoke authorization contact the Compliance department at phone # (915) 521-7490.

I understand EPCHD may not deny treatment based on my completion of this authorization. Copying fees/charges will comply with all laws/ regulations applicable to release of information. *I have read the above and authorize the disclosure of the protected health information as stated.*

_____

Signature of Patient / Legal Representative: Printed Name: Relationship to Patient: Date/Time:

Address / Phone number of requestor (if different from patient information) Authorization must be signed by patient or legal guardian if patient is under 18 years of age. If patient is deceased it must be signed by immediate next of kin with copy of death certificate. If patient cannot sign authorization, Power of Attorney must be presented.

White – EPCHD **Yellow** – Individual (Patient/Legal Representative)

UNIVERSITY MEDICAL CENTER
OF EL PASO

Authorization for the Use & Disclosure of PHI

843-006-03E

Patient Information Sticker