

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
- Reproductive Health Information

- Instructions at Discharge
- Discharge Summary
- Diagnostic Test Results
- Medication Record
- Medication Allergies
- Problem List
- Procedures
- Radiology Report

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

- Other _____
- Other: _____
- Other: _____

Purpose: Medical Care Personal Use Attorney/Legal
Preferred Receipt Method: In-Person Mail E-mail

____ (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