PATIENT NAME: ____________________ **BIRTHDATE:** ____________

ADDRESS: ____________________ **PHONE #:** ____________

E-MAIL ADDRESS: ____________________

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 ____________________

UMC Radiology, Clinics, Patient Financial Services, Address, Phone & Fax #

To Release Medical Record Information from/to Outside Healthcare Facility / Physician office/patient/other

____________________ **(Recipient Name)**

____________________ **(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: ________

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)

_____Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including Genetic Test Results)

_____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month_____ Day_____ Year_____
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.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand the refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
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 disclosure of the protected health information as stated.
A minor individual's signature is required for release of certain types of information, including for example, release of information related to certain types of reproductive care, sexually transmitted disease, drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

____________ ____________________ ____________________

Date | Signature of Patient / Legal Representative | Relationship to Patient

____

Address / Telephone # 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.

Original – EPCHD Copy – Individual (Patient/Legal Representative)

Authorization for the Use & Disclosure of PHI

843-006-03E(rev10/19) (b/w,8.5x11,2ptNCR 5hpt)

Patient Identification Sticker