PATIENT NAME: _____ BIRTHDATE:_____ SOCIAL SECURITY #: _____

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) 521-7688

OR _____
Radiology, Clinics, Patient Financial Services

_____

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 _____

___(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 redisclosure 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.

_____	_____	_____
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.

AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

UNIVERSITY MEDICAL CENTER
OF EL PASO