PRINT SAVE AS EMAIL RESET

BAYLOR SCOTT & WHITE HEALTH
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 may be 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.

Patient Name	Last 4 of Social Security Number	Date of Birth MM DD YYYY	Acct #	MRN

Street Address	City, State	Zip

Telephone Number	Email:

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

Individual/Organization Name		Telephone Number
Colon & Rectal Associates of Texas		(972) 612-0430
Street Address	**City, State, Zip**	**Fax Number**
1705 Ohio Drive, Suite 100	Plano, TX 75093	844-585-6193

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

Record copy delivery: If you have requested records be sent to you directly, we will send you an email with a link to download them, unless you specify otherwise: ☒ Fax to healthcare provider/facility ☐ Mail ☐ PDF via email ☐ MyBSWHealth ☐ Other _____

Information to be released from these BSWH facilities: ☒ Clinic visits ☒ Hospital visits ☐ _____ **(Specify Provider or Location)**

Please release the following information for treatment dates: from _____ to _____

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

☐ Summary Abstract only (clinic notes, history & physical, procedure reports, pathology, consultations, test results, discharge summary)

☐ Clinic Notes	☐ Consultations	☐ Laboratory	☐ Radiology Images (CD only)
☐ Emergency Department	☐ Discharge Summary	☐ Medication	☐ Radiology Reports
☐ Billing Record	☐ History & Physical	☐ Operative Reports	
☐ Complete Chart (Fee)	☐ Immunization	☐ Progress Notes	

☐ Other: _____

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

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)

Scan doc type: Authorization to Release Protected Health Information

BAYLOR SCOTT & WHITE HEALTH

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