HILL COUNTRY MEMORIAL HOSPITAL
Post Office Box 830 / Fredericksburg, Texas 78624
The Hill Country's Hospital / hillcountrymemorial.org

MED RECORD NO.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize you to release ***hospital*** information from the medical record of:

PATIENT NAME	DATE OF BIRTH

The information is to be released:

TO				FROM	
	AUTHORIZED PERSON'S NAME				**Hill Country Memorial Hospital** 1020 S. State Hwy 16/P.O. Box 835 Fredericksburg, TX 78624 Ph: 830-997-1280 Fx: 830-997-1261
	ADDRESS:	EMAIL ADDRESS: (if applicable)			
	CITY	STATE	ZIP CODE		DATE(S) OF SERVICE

INFORMATION TO BE RELEASED					
☐	Discharge Summary	☐	Operative Report	☐	Emergency Record
☐	History & Physical	☐	Consultation	☐	Outpatient Record
☐	Pathology Report	☐	Lab Report	☐	X-ray Report / Image Disc
☐	Rehabilitation Record	☐	Physician Progress Notes	☐	Physician Orders
☐	Nurses Notes	☐	Medication Record	☐	Add Authorized Person To My Portal
☐	EKG	☐	Itemized Bill	Other, please specify:	

PURPOSE OF DISCLOSURE			
☐	Attorney/Legal	☐	Continued Patient Care
☐	Insurance	☐	Personal Use
☐	Worker's Compensation	☐	Other:

It is understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. **I understand that records from other health care providers will not be released with this request, only hospital records.** I hereby waive my/his/her right to the privileges of confidentiality with respect to any HIV test result or mental health information or drug and alcohol information that may be contained in the medical record. The health care provider, its employees and officers and physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. A photocopy or facsimile of this authorization shall be deemed to have the same force and effect as the original. I further understand that I may revoke this consent in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance thereon. **This consent will expire 180 days (6 Months) after date of signature.** If the PHI is re- released or if the release is to a non-covered entity it will no longer be protected.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PATIENT/GUARDIAN (if required)	DATE
SIGNATURE OF WITNESS	DATE

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