CASTRO COUNTY HOSPITAL DISTRICT

P.O. Box 278
Dimmitt, TX 79027
(806)647-2191 · Fax (806)647-0934

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name ______________________ Daytime Telephone Number ______________________

Birth Date __________ SS# __________ Treatment Dates From __________ To __________

INFORMATION REQUIRED		REASON FOR REQUEST
□ Diagnostic Tests □ Radiology Reports □ Lab Reports □ Pathology Reports □ Other (specify):_______________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________	□ History & Physical □ Consultation □ Operative Reports □ Progress Notes □ Discharge Summary □ Entire Record □ Statements of charges/pmts □ Copies of records or reports provided to the facility listed below (i.e. hospital, lab, clinic, etc.) □ Photos, videotapes, digital or other images □ Other (specify):___________	□ Continued Treatment □ Insurance □ Patient's Personal Record □ Legal □ Other (specify) ____________________ __________________________________ __________________________________ __________________________________ __________________________________ __________________________________ __________________________________ __________________________________ __________________________________ __________________________________

INFORMATION TO BE RELEASED TO:	INFORMATION TO BE RELEASED FROM:
	Plains Memorial Hospital
Name [Facility, Agency, Physician, etc]	Name [Facility, Agency, Physician, etc]
	310 West Halsell St
Address	Address
	Dimmitt **TX** **79027**
City State Zip	City State Zip

I understand that this Authorization to Release Protected Health Information specifically includes any and all records, regarding testing, diagnosis, evaluation, or treatment for mental or emotional conditions, alcoholism, drug addiction, HIV infection or AIDS. Any and all records, whether oral or in electronic format, are confidential and cannot be discussed without my prior written authorization, except as otherwise protected by law.

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I understand that *Plains Memorial Hospital/Castro County Hospital District* will not condition treatment or other benefits on my signing this Authorization. I understand that once information is disclosed under this Authorization to someone who is not a healthcare provider, the information may no longer be protected by federal privacy rules and could be disclosed to others by the recipient. I also understand that I have the right to revoke this Authorization at any time, except to the extent that *Plains Memorial Hospital/Castro County Hospital District* has taken action in reliance on the Authorization, by delivering or sending written notice of revocation to *Plains Memorial Hospital/Castro County Hospital District* at the address above. If I do not revoke this Authorization, it will expire in sixty (60) days.

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With this knowledge, I give my consent to □ release or □ obtain the protected health information as specified above and release the organization, its duly authorized employees and agents from any liability in connection with the release of the specified information and pursuant to this signed Authorization to Release Protected Health Information.

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A copy of this release has the same force and effect as an original.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Person Authorized to Consent for Patient Name & Relationship (if signed by anyone other than patient [parent, legal guardian, personal representative, etc.])

Reason patient is unable to sign______________________________ Witness______________________________

Date______________________________