# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BSWH)

I hereby authorize:

| Individual/Organization Name | | Telephone Number |
|---|---|---|
| Street Address | City, State, Zip | Fax Number |

to disclose my individually identifiable health information as described below. I understand the following:

- This Authorization is voluntary and I may refuse to sign this document.
- My health care and the payment of my health care will not be affected if I do not sign this form.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization at any time by notifying the disclosing individual/organization listed above in writing. This revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.
- This authorization will expire in 180 days or at the date or event specified here: ______________________________

| Patient Name | Date of Birth | Acct # | MRN |
|---|---|---|---|
| Street | City | State | Zip |
| Telephone number | Email: | | |

**The information will be released TO:**

| Individual/Organization Name: **Baylor Scott & White Health** | | | Telephone Number 979-207-0616 |
|---|---|---|---|
| Street Address 700 Scott & White Drive | City College Station | State Texas | Zip 77845 |
| Fax number 979-207-0613 | Email BSWHCSHIM@BSWHealth.org | | |

**Purpose: Continued Care**

**Record copy delivery:** ☐ Fax to healthcare provider/facility ☐ Mail ☐ Email ☐ Other ______________________________

**Please release the following information for treatment dates:** from ______________ to ______________

**Include this information if applicable:** ________Alcohol/Drug ________Genetics ________ HIV/AIDS ________Mental Health
(PT INITIALS under each blank)

☐ 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 | ☐ Immunization | ☐ Progress Notes | |

☐ Other: ______________________________________________

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**

BSWH-59809 (Rev. 03/24)

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