1814 Roseland Blvd | Suite 100 | Tyler, Texas 75701
903-525-3413 Office | 903-525-3399 Fax
MedicalRecords@tsjh.org

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Texas Spine and Joint Hospital 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 may revoke this authorization by notifying Texas Spine and Joint Hospital, in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Name	Last 4 of Social Security Number	Date of Birth MM DD YYYY	Acct #	MRN
Street Address	City, State,	Zip	Telephone Number	

Please release the following information for these treatment dates: ______________________________

The information will be released to: ☐ Patient/Designee ☐ Health Care Entity ☐ Other

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

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Personal Use

Record copy delivery: ☐ Pick-up ☐ Mail ☐ Fax_____________________ ☐ Email_____________________________

_________ *I UNDERSTAND THAT ANY RECORDS RELEASED VIA FAX OR EMAIL ARE SUBJECT TO ACCIDENTAL DISCLOSURE.*

Information to be released:

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

☐ Emergency Department	☐ Discharge Summary	☐ Medication	☐ Provider Orders
☐ Billing Record	☐ History/Physical	☐ Nurses' Notes	☐ Radiology Film
☐ Complete Chart (Fee)	☐ Immunization	☐ Operative Reports	☐ Radiology Reports
☐ Consultations	☐ Laboratory	☐ Progress Notes	
☐ Alcohol/Drug			

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

By signing 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

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Representative's Authority to Act for Patient
(attach supporting documentation)