WHITE ROCK MEDICAL CENTER
9440 Poppy Drive Dallas, Texas 75218
Fax | 214.324.6690 Phone | 214.324.6122

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CITY HOSPITAL™ EMERGENCY CARE CENTER

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Please check the box above to the right of the facility from which you received services and would like the records

RELEASE OF INFORMATION

All sections must be completed for a valid authorization.

Patient Name:	**Birth Date:**	**Last 4 Digits SSN (optional):**
Patient Alias(s):	**Patient Contact Number:**	
Recipient's Name:	**Recipient's Phone:**	**Recipient's Fax:**
Recipient's Address (City, State, Zip):		

Request Delivery: ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, CD/DVD)** ☐ **Encrypted Email** ☐ Fax
☐ **Confidential download if available**
NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided

Email Address (If email checked above. Please print legibly):

Purpose of disclosure:

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Abstract ☐ Clinical Test(s) ☐ ER Records ☐ Discharge Instructions ☐ Operative Documentation ☐ Clinical Test(s) (Labs) ☐ History and Physical ☐ Consultation Reports ☐ Operative Record ☐ EKG/ECHO ☐ Physician Progress Notes ☐ Physician Orders		☐ Medication Sheets ☐ Entire medical record ☐ Blood Type ☐ Itemized Bill ☐ Face sheet ☐ Pathology Report ☐ Radiology Films/CD ☐ Radiology Reports ☐ Other:		**Confidential Information** ☐ HIV Testing ☐ HIV & AIDS Documentation ☐ Psychiatric Documentation ☐ Alcohol & Drug Use Documentation ☐ Psychotherapy Notes (If checked, this is the only thing that can be processed on this form.)	

This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:
Expiration Date: **or** **Expiration Event**:

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
6. I will be offered a copy of this form after I sign it.

If the request of PHI is for the purpose of marketing and involves the sale of PHI the healthcare provider must complete the information below.

Provider box only

Will the recipient receive financial remuneration in exchange for using or disclosing this information, if no respond with a No on the line below, if yes, describe here and answer the question below:

_____

May the recipient of the PHI further exchange the information for financial remuneration?

I have read the above or had it read to me and I authorize the disclosure of the Protected Health Information as stated from WHITE ROCK MEDICAL CENTER

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative: **Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*	**Relationship to Patient:**

Identification Verified by: _____ ☐ State Issued Photo Identification _____ ☐ Other