☐**METHODIST DALLAS MEDICAL CENTER**
1441 N. Beckley Ave., Dallas TX 75203
Phone 214-947-2800 Fax 214-947-7632

☐**METHODIST MANSFIELD MEDICAL CENTER**
2700 E. Broad St., Mansfield, TX 76063
Phone 682-242-6120 Fax 214-947-7632

☐**METHODIST MIDLOTHIAN MEDICAL CENTER**
1201 East U.S. Hwy 287, Midlothian, TX 76065
Phone 469-846-6700 Fax 214-947-7632

☐**MDMC GOLDEN CROSS ACADEMIC CLINIC**
122 W Colorado Blvd, Dallas, TX 75208
Phone: (214) 947-6700

☐**METHODIST CHARLTON MEDICAL CENTER**
3500 W. Wheatland Rd., Dallas, TX 75237
Phone 214-947-7600 Fax 214-947-7632

☐**METHODIST RICHARDON MEDICAL CENTER**
2831 E. President George Bush Hwy., Richardson, TX 75082
Phone 469-204-0500 Fax 214-947-7632

☐**METHODIST SOUTHLAKE MEDICAL CENTER**
421 E. State Hwy 114, Southlake, TX 76092
Phone 817-865-4643 Fax 628-335-0506

☐**METHODIST CHARLTON FAMILY MEDICINE CENTER**
3500 W Wheatland Rd, Dallas, TX 75237
Phone: (214) 947-5400

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

ONCE COMPLETED, PLEASE EMAIL TO MHSROI@MHD.COM

Name of Individual Authorized to Make Request (i.e. Your Name): _____
Patient's Name: _____
Patient's Street Address*:* _____
Patient City & State: _____ Patient Zip Code: _____
Patient Home Phone: _____ Patient's Date of Birth: _____ Patient Age: ____ Patient Sex*:* ____
Patient Social Security #: _____ Patient Medical Record Number*:* _____
Date of Admission: _____ Discharge Date: _____

1. I authorize the organization indicated above to use the above mentioned patient's health information and make the disclosure to the following individual(s) or organization(s) via the following delivery methods for the following purposes:

Name of Individual/Organization Receiving PHI: _____
Preferred Delivery Method (Must check at least 1):

□ Mailed via postage – mailing address: _____
□ Encrypted email (It should be noted if the file size is too big to send via email, you will be contacted for an alternative delivery method): _____
□ Pick up in person at the hospital
□ MyChart (electronically and will only receive part of the medical record)
□ Other Delivery Method: _____

Purpose of Disclosure (Must check at least 1):

☐ Personal Use ☐ Treatment/Continuing Medical Care ☐ Billing or Claims ☐ Insurance ☐ School ☐ Employment
☐ Legal Purposes ☐ Disability Determination ☐ Other: _____

2. **The type and amount of information to be used or disclosed is as follows: (Please Check)**

☐ **Entire Health Record** ☐ Discharge Summary ☐ Past/Present Medications ☐ Operative Procedures ☐ Pathology Reports
☐ Consultation Reports ☐ Lab Reports ☐ Imaging Reports ☐ Billing Information ☐ X-Ray Film
☐ Echocardiogram ☐ Patient Allergies ☐ Clinic Records ☐ ER Records ☐ Progress Reports
☐ History & Physical ☐ Pathology Slides ☐ Other: _____

3. I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **Therefore, your initials are required to release the following information:**

_____ Mental Health Records (excluding psychotherapy notes) _____ HIV/AIDS Test Results/Treatment
_____Drug, Alcohol, or Substance Abuse Records _____ Genetic Information (including Genetic Test Results)

Please read the following prior to signing this Authorization:

- **Revocation:** I understand that I have the right to revoke this authorization at any time by sending written revocation to MHSROI@mhd.com. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I want this authorization to expire upon a date, event, or condition, I will notify MHSROI@mhd.com. **Unless otherwise revoked or indicated to MHSROI@mhd.com, this authorization will expire six (6) months from the date of signing.**
- **No conditions:** We will not condition payment, treatment, enrollment, or eligibility for benefits on completion of this authorization.
- **Continued Disclosure:** I have read this form and agree to the use and disclosures of information described herein. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy regulations. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or any other disclosures permitted by law.
- **Copy:** If a written request is sent to MHSROI@mhd.com, I understand that I may be given a copy of this form after signing.

_____ _____
Signature of Patient/Responsible Party or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Date