Authorization for Release of Protected Health Information

I authorize the following facility(s):

- ☐ The Hospitals of Providence – Horizon City
- ☐ The Hospitals of Providence – Montwood
- ☐ The Hospitals of Providence – Northeast

to release information from the record of:

Patient Name:____ Date of Birth: ____________________

Address:____
Street City State Zip code

Patient Phone Number: ____

as described below, the information will be released to:

Facility/Person to Receive Records ____

Phone:______________________________ Fax/Email: ______________________________

Address:____
Street City State Zip code

I have been a patient at your facility or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

Place a check by types of records desired:

☐ Entire Clinical Record	☐ History & Physical Exam	☐ Physician Orders
☐ Discharge Summary	☐ Medication Administration Records	☐ Physician Progress Reports
☐ Laboratory Reports/Tests	☐ Psychiatric/Psychological Evaluation	
☐ EKG Report	☐ Radiology Report	
☐ Nurses Notes	☐ Pathology Report	
☐ Emergency Department Report	☐ Abstract *(history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports)*	
☐ Consultation Reports	☐ Billing or other business records *(specify)*: ____________________	

☐ Other *(specify)*:____

HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)

Reason for Request:

☐ Continuing treatment	☐ Employer	☐ Insurance	☐ Study/Research
☐ Legal	☐ Disability	☐ I do not wish to disclose the reason	

☐ Other: ____

Dates of Service for record requests:____

This authorization will expire in six months or: ____

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

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I understand that this authorization is subject to revocation at any time, except to the extent that The Hospitals of Providence has already taken action in reliance upon it or to the extent previously disclosed within the HIPAA NOTICE OF PRIVACY PRACTICES for Treatment, Payment, and/or Business Operations. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and deliver to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive, and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature ____ Date_____________ Time_____________

If representative, give relationship and authority to act ____

If authority to act is a Power of Attorney, supporting documentation must be included with this request.

Identity of requestor verified via ________ Photo ID ________ Matching Signature ________ Other, Specify _________________

Witness Signature ____ Date_____________ Time_____________

Witness Signature ____ Date_____________ Time_____________

All release of information requests must be sent directly to the corresponding facility. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

The Hospitals of Providence Horizon City
Attn: Medical Records Dept.
13600 Horizon Blvd.
Horizon City, TX 79928
Phone: 915-407-7878
Fax: 915-852-1804

The Hospitals of Providence Northeast
Attn: Medical Records Dept.
11274 McCombs St.
El Paso, TX 79934
Phone: 915-242-2400
Fax: 915-822-2160

The Hospitals of Providence Montwood
Attn: Medical Records Dept.
1890 George Dieter Dr.
El Paso, TX 79936
Phone: 915-225-7100
Fax: 915-304-0240