PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

AUTHORIZATION FOR RELEASE OF INFORMATION

ARI260

Patient Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ MRN _____

Telephone # _____

I hereby authorize Parkland Health & Hospital System (PHHS) to release the information specified below from the medical record(s) of the above named patient.

The information shall be released to: **Date of Service:** From _____ to _____

Hoosier Services Inc.
Name of Person/Organization

18032 Lemon Drive, Suite C-618, Yorba Linda, CA 92886
Address, City, State, Zip Code

800.882.4156 Phone Number

800.882.4957 Fax Number

Patient information is needed for (*Please select only one*):

☐ Continuing Medical Care ☐ Legal Purposes ☐ Insurance/Billing/Claims
☐ Personal Use ☐ Social Security/Disability ☒ Other (explain) Life Insurance

Information to be released or accessed (*Please check all that apply*):

☐ Consultation Reports ☐ Discharge Summary ☐ Emergency Room Record ☐ Face Sheet
☐ History and Physical ☐ Laboratory Reports ☐ Operative Reports ☐ Pathology Reports
☐ Progress Notes ☐ Radiology Reports ☐ Other _____

Format requested for information to be provided:

☒ Paper ☐ MyChart
☐ CD (Applies only to data stored electronically)

Delivery Method:

☒ Mail ☐ Pick-up ☐ MyChart
☐ Fax (Healthcare Organization Only)

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, communicable diseases, HIV testing and treatment, psychiatric treatment, and genetic testing. To authorize release of this information, please read and initial the information to be released:

_____ *Patient Initials* I authorize the release of **alcohol and/or drug abuse** treatment and information.

_____ *Patient Initials* I authorize the release of **HIV test results** and/or HIV treatment information.

_____ *Patient Initials* I authorize the release of **psychiatric** information.

_____ *Patient Initials* I authorize the release of **genetic testing** information.

I understand that I may revoke this authorization in writing at any time, except to the extent that PHHS has relied on this authorization. The written revocation should be addressed to **PHHS – Health Information Management Division – Release of Information – 5201 Harry Hines Blvd. – Dallas, TX 75235**. Unless otherwise revoked, I understand that this authorization expires in One Hundred and Eighty (180) days from the date of signature or on _____. A copy of this authorization is considered as valid as the original.

I understand that the recipient authorized to receive the health information is not a covered entity (e.g. non-health care provider) the released information may be redisclosed and may no longer be protected by federal and state privacy regulations.

I understand that PHHS will not condition treatment, payment, enrollment, or eligibility for benefits based on completion of this form. I understand I may be charged a fee for copies of medical records.

_____ Patient or Decision-Making Surrogate Signature
_____ Patient or Decision-Making Surrogate Printed Name
_____ Date
_____ Time

_____ Relationship to Patient, if applicable

_____ Interpreter Signature, if applicable
_____ Interpreter Printed Name
_____ ID #
_____ Date
_____ Time