



**HILL COUNTRY
MEMORIAL HOSPITAL**
A part of Hill Country Memorial Health System

1020 South State Highway 16 • Fredericksburg, Texas • (830) 997-4353 • www.hcmhs.org

MED RECORD NO.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize you to release information from the medical record of:

PATIENT NAME	D.O.B
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The information is to be released:

T O	NAME	F R O M	Hill Country Memorial Hospital	
	ADDRESS		P.O. Box 835	
	CITY STATE ZIP CODE		Fredericksburg, TX 78624	
			DATE OF SERVICE	

INFORMATION TO BE RELEASED

Discharge Summary	Operative Report	Emergency Record
History & Physical	Consultation	Outpatient Record
Pathology Report	Lab Report	X-ray Report
Rehabilitation Record	Physician Progress Notes	Physicians Orders
Nurses Notes	Medication Record	Other, please specify:
EKG	Itemized Bill	

PURPOSE OF DISCLOSURE

Attorney/Legal	Continued Patient Care
Insurance	Personal Use
Worker's Compensation	Other:

It is understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. I understand that records from other health care providers will not be released with this request. I hereby waive my/his/her right to the privileges of confidentiality with respect to any HIV test result or mental health information or drug and alcohol information that may be contained in the medical record. The health care provider, its employees and officers and physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. A photocopy or facsimile of this authorization shall be deemed to have the same force and effect as the original. I further understand that I may revoke this consent in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance thereon. This consent will expire 180 days after date of signature. If the PHI is re-released or if the release is to a non-covered entity it will no longer be protected.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PATIENT/GUARDIAN (if required)	DATE
SIGNATURE OF WITNESS	DATE