WESTSIDE
SURGICAL HOSPITAL

Authorization for Release of Individually Protected Health Information

Patient Name_____ D.O.B_____SS# _____

Address_____City_____State_____Zip_____

Contact # Home_____Work#_____Cell#_____

I, _____, hereby authorize Westside Surgical Hospital to use or disclose the following Protected Health Information: Treatment Date(s):

_____

- ☐ Abstract/Pertinent Information (Includes portions below) ☐ Entire Record
- ☐ H&P ☐ Itemized Bill
- ☐ Discharge Summary (If Applicable)
- ☐ Operative Report
- ☐ Lab/Pathology Reports
- ☐ Imaging/Radiology
- ☐ EKG
- ☐ Anesthesia Record

The protected health information may be disclosed to:

_____

Name/Address of person/organization to which disclosure is to be made

Purpose for disclosure: ☐ Medical Care ☐ Legal ☐ Insurance ☐Other (specify) _____

I understand that, as set forth in the Provider's Privacy Notice, I have the right to revoke this authorization at any time by sending written notification to:

Westside Surgical Hospital
4200 Twelve Oaks Drive
Houston, TX 77027
Attention: Medical Records Coordinator
Fax: (832)-701-2955

This authorization is valid until the 90th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above. Once information is released per authorization, that authorization is no longer valid, i.e. for each request, a new authorization form is required. A copy or facsimile of this authorization is as valid as the original. I understand that I have the right to refuse to sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal or state law.

Information to be released may include, but is not limited to records concerning psychiatry, chemical dependency, and HIV/AIDS.

I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____

Date Signature of Patient or Legal Representative Authority/Relationship to