Matagorda Episcopal Health Outreach Program (MEHOP)
101 Avenue F North, Bay City, TX 77414
979-245-2008 / Fax: 979-258-1213

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize MEHOP to ***release*** medical information concerning:

Patient Name_____DOB_____SSN_____

Address _____

City_____State_____Zip _____

Telephone Number _____

This information is to be ***released to***:

Name _____
Address_____
City_____State_____Zip_____
Telephone Number _____
Fax Number _____
Email _____

Instructions

- **Please release the following information, indicated by an "X":**
  __Complete Medical Record __History & Physical __Discharge Summary __Operative Report(s) __Consultation Report
  __Emergency Report __Medication List __Lab Results __Imaging Report __Vaccination History
  __Other _____

- **I give special permission to release any information regarding items listed below:**
  (INITIAL)___HIV Medical Records____Psychiatric Record____Substance Abuse Record___Psychotherapy Notes

- **Please release only the information pertaining to the following dates**
  from_____to_____.

- **This information is being disclosed for the following purpose:**
  ___Follow up care____Transfer of Care___Patient Request*____Disability Benefits __Attorney**
  _____Other* Please Explain _____

*The charge for medical records shall be no more than $25 for the first twenty pages and $0.25 per page for every copy thereafter. The charge for submitting medical records electronically in the form of a PDF shall be a flat fee of $25 regardless of the number of pages. There shall be no charge for records posted directly to the patient portal.

***Attorney slightly higher than all other requests.

- **Please release my information by:** ___Mail____Orally____Pick-up___Fax___Secure Email

Acknowledgment

The patient or the patient's authorized representative must read the following statements:
I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (otherwise specified date_____). I understand that the provision of health care and the payment for any health care will not be affected if I do not sign this form. Upon expiration MEHOP can no longer use or disclose my information for the above purposes without a new authorization. All revocation will be sent to the attention of the Medical Records Clerk and become effective once received.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients(s) of that information.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

_____ _____ _____
SIGNATURE of Patient or Authorized Representative | Date | RELATIONSHIP to Patient

WITNESS _____

Note: This information is being disclosed to you from records where confidentially may be protected by federal and/or state laws. If so, regulations 42 CFR Part 2 prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.