RELEASE OF INFORMATION REQUEST FORM

DISCLOSURE: I, _____, hereby authorize Dallas Behavioral Healthcare Hospital to release and discuss medical records, (including any information related to medical, surgical, psychological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. Initial: _____

Please release any information FROM:

Dallas Behavioral HealthCare Hospital
(Name)

800 Kirnwood Drive
(Address)

Desoto TX 75115
(City) (State) (Zip)

Please release information TO:

_____
(Name)

_____
(Address)

_____
(City) (State) (Zip)

_____
(Secured FAX or Secured email)

Type of access requested: ☐Inspection of medical record ☐Copy of medical record ☐Verbal exchange of information related to care only

To obtain copies of the medical record, check the appropriate box below:

☐Will pick-up medical record ☐Mail medical record to the address above ☐FAX to the number above ☐e-mail to the address above

A charge for copies of medical record will be assessed, based on Texas copy allowance rule, when the request is for purpose other than care related.

I specifically need the following information released (requests for "any and all records" is NOT acceptable):

☐ Discharge Summary ☐ Psychiatric Evaluation ☐ History & Physical ☐ Physician Orders ☐ Medication Records
☐Intake Assessment ☐ Psychosocial Evaluation ☐Nursing Assessment ☐ Laboratory/X-ray Reports

☐**Other:** _____ ☐Entire Record (reason why**):** _____

The recipient of the information released may use it only for the following purposes (must be indicated):

_____ Assessment & Evaluation _____ Claims Settlement _____ Personal Use
_____ Continued Care & Treatment _____ Military _____ Aid Entitlement
_____ Placement & Aftercare _____ Health Insurance Enrollment _____ Employer
_____ Legal Proceedings or Advice _____ School/Educational Needs _____ Verbal Exchange
_____ OTHER: _____

The information authorized for release may include information which may be considered information about communicable or venereal diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Initial: _____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol& Drug Abuse records (42 CFR, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it, and unless further limited by the following date _____ will expire after a period of 90 days (3 months). I have a right to receive a copy of this authorization upon my request.

DATE	**TIME**	**PATIENT SIGNATURE (IF SIXTEEN YEARS OR OLDER):**	
RELATIONSHIP	**TIME**	**RESPONSIBLE PARTY SIGNATURE**	
RESPONSIBLE PARTY PHONE NO. **HOME ( ) -**		**WORK ( ) -** **CELL ( ) -**	
DATE	**TIME**	**WITNESS SIGNATURE**	**TITLE**
DATE	**TIME**	**PHYSICIAN SIGNATURE**	

INFORMATION RELEASED FROM THE MEDICAL RECORD:
☐Discharge Summary ☐Psychiatric Evaluation ☐History & Physical ☐Physician Orders
☐Medication Records ☐Laboratory/X-ray Report ☐Nursing Assessment ☐Intake Assessment
☐ Entire Record ☐Psychosocial Assessment ☐ Other: _____

Records copied by: _____ Date sent: _____

Via: ☐ U.S. Mail

☐ Pick-up ☐ Secure FAX ☐Secure e-mail

Records given to: _____

_____

_____

Faxed to phone number: (_____) _____

Attention: _____

_____