PHYSICIANS SURGICAL HOSPITALS, LLC
PANHANDLE SURGICAL HOSPITAL QUAIL CREEK SURGICAL HOSPITAL

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____
Address: _____ **Telephone**: _____
_____ **Social Security Number:** _____

Information to be *Released From*:

Hospital: Physicians Surgical Hospitals, LLC
Address: 6819 Plum Creek Drive
Amarillo, TX 79124
Phone: 806 354-6115

Information to be *Released To*:

Name: _____
Address: _____
_____
Phone: _____

Dates of Service Requested: From; _____ **To**: _____ **Records Requested:** (Check all that apply):

- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Pathology Reports
- ❑ EKG Reports
- ❑ ER Records
- ❑ Other: _____
- ❑ Consultations
- ❑ Operative Reports
- ❑ X-Ray Reports
- ❑ Laboratory Reports
- ❑ Anesthesia Records

I am requesting this information be released for the following purposes:

❑ Continued Care ❑ Insurance ❑ Legal ❑ Personal Use ❑ Other: _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This type of sensitive information will only be released if specifically requested by checking "other" above and stating exactly what information is to be released.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.
- I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure of information and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Physicians Surgical Hospitals Medical Records Department at 806 354-6115 or Physicians Surgical Hospitals Privacy Officer at 806 212-2000.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Authority to Sign (Parent, Guardian, Medical POA, etc.) Signature of Witness

See Page 2 for Copy Fees

Physicians Surgical Hospitals, LLC
Medical Record Fees

Effective October 10, 2008

In accordance with §241.154(e) of the Health and Safety Code, Physicians Surgical Hospitals or its agent may charge a reasonable fee for providing the health care information and is not required to permit the examination, copying, or release of the information requested until the fee is paid unless there is a medical emergency.

FOR FOLLOW-UP CARE:

Basic Information will be copied at no charge. Basic information includes:

- Discharge summary, if applicable
- History and Physical
- Consultations
- Operative Reports
- Pathology Reports
- Lab Reports
- Radiology Reports

FOR PATIENTS:

The basic retrieval or copying fee will be as follows:

Pages:	1 – 60	$ 1.43 per page
	61 – 400	$ 0.71 per page
	> 401	$ 0.27

FOR ATTORNEYS, SUBPOENAS, INSURANCE UNDERWRITING, ETC:

The basic retrieval or copying fee will be as follows:

The actual cost of mailing, shipping or otherwise delivering the provided copies, plus

Pages:	1 – 10	$42.54
	11 – 60	$ 1.43 per page
	61 – 400	$ 0.71 per page
	> 400	$ 0.37 per page

Execution of an Affidavit, Certification of a Document or Written responses to a written set of questions will be:

$ 14.40 per set

.