

AUTHORIZATION FOR RELEASE OF INFORMATION

I Hereby Authorize: HEALTHSOUTH Rehabilitation (Name of Facility)
Hospital of Wichita Falls
3901 Armory Rd. (Street Address)
Wichita Falls, TX. 76302 (City, State, Zip)
PH. (940) 716-5062
Fax. (940) 720-5732

to release to: _____ (Specific Person)
_____ (Name of Facility)
_____ (Street Address)
_____ (City, State, Zip)

the following information from the medical records on:

_____ (Name of Patient)
_____ (Date of Birth)
_____ (Social Security)

Information To Be Released:

- | | |
|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Psychiatric History | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> History Physical | <input type="checkbox"/> Integrated Progress Notes |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> EKG,EEG,EMG, Reports |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Psychiatric Evaluation & Admission Note | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Other, Specifically: _____ | |

The information specified above is to be released for the following purpose and that purpose only. Any other use is forbidden:

PURPOSE:

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that this authorization will automatically expire 180 days from the date of my signature. Also, I understand that a photocopy of this authorization is valid for release of my records. I understand that the specific type of information to be disclosed may include a history of the diagnosis and/or treatment of mental conditions, chemical or alcohol abuse and dependency, H.I.V. , and A.I.D.S. , and I have given my specific consent for disclosure of this information as indicated below. Federal law (42CFR, Part2) prohibits redisclosure of this information by the recipient. Medical records photocopies are subject to a prepaid fee.

Signature of Patient
(Required for Minors 16 and Older)

Date Signed

Signature of Parent/Guardian (Required for patients under 16)