Graham Regional Medical Center
P.O. Box 1390
1301 Montgomery Road
Graham, TX 76450

Health **I**nformation **M**anagement
Phone 940-521-5203
Fax 940-521-5150

Graham Regional Medical Center

AUTHORIZATION to RELEASE MEDICAL RECORDS

Name of patient_____ DOB: ____/____/____ Social Security _XXX /____/____ herby authorizes Graham Regional Medical Center and/or its authorized staff to release personal healthcare information (PHI) to:

___**Myself**; ___**Other** (individual with power of attorney, healthcare provider or third party payer, etc)

Name/Organization:_____
Address (current):_____
City:_____State:_____Zip:_____
Fax number (if applicable)_____

For the purpose of: ___Personal use* ___Attorney* ___Continuation of Care ___Disability ___Insurance ___Military ___Other (please specify)_____

Only send the following information requested: Date of visit(s)_____

___ Discharge Summary
___ History & Physical
___ Consultation Report
___ Operative Report
___ Pathology Report
___ Progress Notes
___Lab work
___ Doctors orders
___ X-ray report
___ Emergency Room
___ Ambulance
___ Other _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CARFULLY. This consent/authorization is effective for up to sixty (60) days.

1. **For Treatment.** We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital.
2. **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at Graham Regional Medical Center may be billed to and repayment may be collected from you, an insurance company or third party.
3. **For Healthcare Operation.** We may use and disclose medical information about you necessary to run Graham Regional Medical Center and make sure that all of our patients receive quality care.

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken information already released. Graham Regional Medical Center, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

*When individual stated above, personally comes to Graham Regional Medical Center, a retrieval or processing fee of **.25 cents** each page may be imposed to cover the cost of labor, copying, postage, and preparing a summary of the requested information accordance with the **Texas Health and Safety Code 241.154 and Senate Bill 667,** which is below the Texas standard fee.

_____ _____ _____
Patient's signature (if a minor, parent/guardian) Today's date Staff signature

__items disclosed __Items not disclosed