AUTHORIZATION FOR RELEASE OF INFORMATION

To: Rice Medical Center
P.O. Box 277/600 S. Austin Road
Eagle Lake, Texas

1. I, the undersigned, hereby authorize Rice Medical Center to release the information specified below from the medical record of:

Patient information (Please Print)

First name:	Middle initial:	Last name:	
Date of Birth (MM/DD/YYYY):	Phone:	Email (Optional)	
Street Address:	City:	State:	Zip Code:

2. The purpose of disclosure: _____

_____

3. Information to be released covers the period of:

Date(s) of Service: _____ through _____

Check all boxes that apply:

☐ Discharge Summary	☐ Operative Report	☐ Pathology Report
☐ Lab Report	☐ History & Physical	☐ X-ray Report
☐ Consult	☐ ER	☐ Other:

DISCLOSURE OF RECORDS INDICATED ABOVE MAY INCLUDE INFORMATION REGARDING DIAGNOSIS AND TREATMENT OF DRUGS, ALCOHOL, SUBSTANCE ABUSE, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), HUMAN IMMUNODEFICIENCY VIRUS (HIV) STATUS, SEXUALLY TRANSMITTED DISEASES, OR PSYCHIATRIC DISORDERS.

4. Name of individual or institution that above mentioned information is to be release to:

_____

_____

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

6. I also understand that I may revoke this authorization at any time, but not retroactive to the release of information made in good faith.

7. This authorization is valid until the 90th day after the date it is signed unless specified otherwise.

SIGNATURE: _____ DATE: _____