# Mayhill Hospital

Address: 2809 South Mayhill Rd.
Denton, Texas 76208

Telephone: 940-239-3086
Fax: 940-239-3032

I authorize the Mayhill Hospital to ***release/obtain*** (Circle one) medical Information concerning:

Patient Name_____Date of Birth_____Soc. Sec. No._____

Address_____Dates of Service_____

City_____State_____Zip_____Telephone Number_____

**This information is to be released to/obtained *from*** (Circle one):

Name_____

Address_____

City/State_____Zip_____Telephone #_____

**Please release the following information, indicated by an "X":**

□ History & Physical □ Consultation □ Assessment

□ Lab Results □ Radiology Results □ Treatment Plan

□ Billing Records □ Psychotherapy Notes □ Other_____

□ Discharge Summary □ Medications □ Other_____

| I give special permission to release any information regarding items listed below | **INITIAL** |
|---|---|
| □ **HIV Medical Information** | _____ |
| □ **Psychiatrci** | _____ |
| □ **Substance Abuse Records** | _____ |

**This Information is necessary for the following purposes:**

___Follow-up Care ___Patient is requesting disclosure ___Disability Benefits ___Attorney

___Other (Please Explain)_____ **Indicates Fee for Service if released to patient/guardian**

Please release my information via: ___Mail ___Orally ___Pick-up ___Fax (Fax No._____)

**The patient or the patient's representative must read the following statements:**

**I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date_____). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, the Mayhill Hospital can no longer use or disclose my information for the above purposes without a new authorization.**

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

**I understand any of the above requested information may include results of sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.**

**I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it.**

---

**TO THE PARTY RECEIVING THIS INFORMATION:** This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

_____ _____ _____

**SIGNATURE** of Patient or Authorized Party Date **RELATIONSHIP** to Patient

**WITNESS**_____ **REASON** Patient is Not Signing_____