

**TEXAS SCOTTISH RITE HOSPITAL  
FOR CHILDREN**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

TSRHC #: \_\_\_\_\_

**Request to Outside Facility for  
Disclosure of Health Information**

Main Campus: 2222 Welborn St., Dallas, TX 75219       North Campus: 5700 Dallas Parkway, Frisco, TX 75034

Send to attention of: \_\_\_\_\_ Physician: \_\_\_\_\_

Records Requested from: \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Name of Legal Representative (if other than parent): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

1. I hereby request and authorize the disclosure of the above named individual's health information to Texas Scottish Rite Hospital for Children, at the address indicated above:

2. Purpose of Request: The individual named is:

- Applying for treatment       Scheduled to receive medical care  
 Presently receiving medical care at Texas Scottish Rite Hospital for Children

**RECORDS NEEDED BY:** \_\_\_\_\_

3. The type and amount of information to be disclosed is as follows: *(include dates where appropriate)*

- History and physical exam report dated \_\_\_\_\_ to \_\_\_\_\_  
 X-ray reports dated \_\_\_\_\_ to \_\_\_\_\_  
 X-ray Films (Specify) \_\_\_\_\_  
 Discharge summary report \_\_\_\_\_ to \_\_\_\_\_  
 Clinic reports \_\_\_\_\_ to \_\_\_\_\_  
 Psychological reports dated \_\_\_\_\_ to \_\_\_\_\_  
 Anesthesia records       Consultation reports from Dr. \_\_\_\_\_  
 Laboratory reports dated \_\_\_\_\_ to \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

4. I understand that the information in my (my child's) 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, alcohol or drug abuse, and/or social and family related matters.

5. I understand that this authorization will remain in effect for 1 year from the date signed. I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at the facility from which the records were requested. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. I understand that authorizing the disclosure of this health information is voluntary and that my (my child's) health care treatment and eligibility for benefits will not be affected if I do not sign this form.

7. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and federal and state privacy laws may no longer protect the information.

8. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosures of my health information, I can contact the Health Information Management Department at the facility from which the records were requested.

9. I understand and authorize that information may be disclosed electronically pursuant to this authorization.

He recibido y revisado la versión en español de este consentimiento. (I have received and reviewed a Spanish-language version of this authorization form.)

Signature

Relationship to Patient

Date

*original to outside facility; copy to medical record; copy to patient*

