MONTGOMERY COUNTY HOSPITAL DISTRICT
P.O. BOX 478
CONROE, TX. 77304
(936) 523-1155 FAX (936) 539-1163
RecordsManagement@mchd-tx.org and/or cjarosek@mchd-tx.org

Authorization to Use and Disclose Specific Protected Health Information

PLEASE INCLUDE A COPY OF CURRENT TDL FOR SIGNATURE VERIFICATION
(Texas Driver's License)

Patient's Name (print):______________________________
Date of Service (Injury/Accident):______________________________
Complete Address: ______________________________
Patient's birth date:______________________________
Patient's Social Security number:______________________________
Home Phone #:______________________________
Email address: ______________________________

I hereby authorize MONTGOMERY COUNTY HOSPITAL DISTRICT to disclose records and communications obtained in the course of my evaluation and/or treatment to:

- (Name and address of person or organization to which disclosure is to be made)

Name:______________________________
Address:______________________________
Phone:______________________________
Email Address:______________________________

Reason or purpose for releasing protected health information:______________________________
____

Type of access requested: __________ Copies of record __________ Inspection of record

Requested Medical Records:

_____________ Entire Ambulance Record

_____________ Ambulance Billing Record

_____________ Communications between certified emergency medical services personnel providing medical supervision and the patient while made in the course of providing emergency medical services to the patient.

I understand that I have the right to revoke this Authorization at any time except to the extent that action has already been taken and if not earlier revoked. To revoke this Authorization, I understand that I must contact the privacy officer at the medical provider's location.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization.

A copy or facsimile of this authorization is as valid as the original.

I acknowledge that I have read the provisions in this Authorization and that I have right to refuse to sign this Authorization. I understand and agree to its terms and authorize the disclosure of the protected health information as stated.

____
Printed Name

PLEASE INCLUDE A COPY OF CURRENT TDL FOR SIGNATURE VERIFICATION

____
(Signature of patient or legal representative)

____
Date

- If signed by other than patient, indicate relationship and submit authority:

____

____

This authorization expires 180 days from the date of signature:

____________________ (expiration date).

- **Authorized representative must submit copies of legal documents supporting his or her authority to act on the patient's behalf.**