

Consent for Use and Release of Information

I authorize the release of my healthcare information for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me. I will provide those individuals with a password or other verification means as specified by the Hospital.

I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. I also permit the Hospital to release my healthcare information to my employer, _____ or employer's designee when

(Name of Employer)

the services delivered are related to a work-related injury. If the patient is covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carrier for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, and/or infectious diseases including, but not limited to blood-borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including, without limitation, physicians, nurses, and other health care workers at the Hospital, home health agencies, ambulance companies, and/or such other health care agencies involved in my care during and after transfer or discharge from the Hospital.

I acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted or compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel and physicians involved in my care and their offices. I also acknowledged that should I be treated at another facility in the area affiliated with Hospital, my medical records may be made electronically available to the other facility and physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release Hospital or its authorized representative to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Hospital's behalf conducting patient satisfaction surveys and other studies.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device that I may receive.

I authorize that my religious preference may be released to local religious organization(s) if requested by me.

Date	1, hereby certify I have read, and fully and completely understand this Authorization for Release of Information / Healthcare Information, and that I have signed this Authorization for Release of Information / Healthcare Information knowingly, freely, and voluntarily.		
Time	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> Patient is medically unable to sign the Consent for Use and Release of Information. <input type="checkbox"/> Patient Refused to Sign	
Patient/Parent/Guardian		If other than patient, indicate relationship	
Spouse (if Married/Available)		Witness (to Signature only)	

GREEN OAKS HOSPITAL 7808 Clodus Fields Drive • Dallas, TX 75251
(972) 991-9504

Consent for Use & Release

- ADMIN -

PATIENT IDENTIFICATION

 DPCO0218 (Rev. 08/10)