TEXAS MEDICAL INSTITUTE

Standard Authorization Form
To Use or Disclose Protected Health Information (PHI)

Patient Name: _____ Date: _____

Address: _____ SS#:xxx-xx- ____ ____ ____ ____

_____ D.O.B: _____

Receive Records From:

_____
_____
_____
_____

Release Records To:
Texas Medical Institute
3304 SE Loop 820, Ste B
Fort Worth, TX 76140
Phone: 817-615-8633
Fax: 817-984-1857
medicalrecords@tmidfw.com

Please send a copy of my records as indicated for date(s) of Treatment: _____

Specifically:

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ MD Progress Notes
- ☐ Nursing Notes
- ☐ Social Serv. Notes
- ☐ Laboratory
- ☐ Radiology
- ☐ EEG/EKG/CAT Scan
- ☐ MD Orders
- ☐ other please specify:

_____
_____

Purpose for releasing medical information _____

_____

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

Date: _____

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

Date: _____

Permission to FAX records for medical emergency? ☐ Yes ☐ No