First Surgical Hospital
4801 Bissonnet
Bellaire, Texas 77401
713-275-1111
713-275-1105(fax)

First Street Surgical Center
411 N. First Street
Bellaire, Texas 77401

RELEASE OF MEDICAL INFORMATION/BILLING

_____

Name: **Phone Number**

_____

Address: **City** **State** **Zip Code**

_____

Date of Birth

I hereby freely, voluntarily, and without coercion, authorize First Surgical Hospital/ First Street Surgical Center to release a copy of my medical records for the purpose of review and examination and further authorize and requests that First Surgical Hospital/ First Street Surgical Center provide such copies as requested:

_____

Name **Phone Number**

_____

Address **City** **State** **Zip Code**

The reason for disclosure is _____

No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse, HIV testing and /or AIDS related information unless indicated below. However, the recipient of this information may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Dates of Service:_____

___Discharge Summary
___History and Physical
___Operative Report
___Pathology Report
___Radiology Report
___Other_____
___ Itemized bill
___Lab Studies
___Progress Notes
___Physician Orders
___Consultation
___Entire Record

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), the information described above may be re-disclosed and no longer protected by these regulations. I understand that I may revoke this authorization in writing at any time and that if no date is given this authorization will expire in 90 days _____(Date).

_____

Patient (or legal guardian/power of attorney) **Date**

_____

Witness Signature **Date**