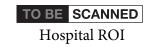


## Authorization to Release Protected Health Information



This form collects information that is part of the medical record.

MR	Number	Name (First, Middle, Last)			Birth Date (Month DD, YYYY)	
Instri	ıctions: If any section is	incomplete, this form may be invalid.				
	ease Information		Release	Information	n To	
□Val Verde Regional Medical Center			□ @S V	□ @S_ W		
	Other (Specify facility/individual & address below, including phone/fax if known.)		Other (Specify facility/individual & address below, including phone/fax if known.)			
			85j °:		3ftention To:	
Puri	pose of Release				<del></del>	
	eatment/Continued Care	☐ Personal	☐ Legal	Purnoses		
	oplication for Insurance	☐ Disability Determination	_	nt of Insurance C	laim	
Info	rmation To Be Re	eleased				
	uired - check all that app			Dt.	□ Dadiala wa Dawasta	
	7` f[dWDWadV	<ul><li>☐ Hospital Discharge Summary</li><li>☐ EKG's</li></ul>	☐ Laboratory Reports ☐ Radiology Reports ☐ Radiology Images			
	listory and Physical lospital Notes	☐ 5a`eg'faf[a`/efi ☐ Pathology Reports ☐ Billing Information				
-	ther (specify information to be released in the space TWVVV					
— other (specify information to be released in the space Tvetvy)						
					Ш	
Service Dates (Optional) From To				Information Needed By (Optional)		
HIV/AI Revoo sign t may b	DS, and genetics. This at action must be made in whe authorization. I may be subject to redisclosure	uthorization may be revoked at any time vriting to the provider/facility releasing th	except to the e e information. rith state law. protected by fe	extent that action The provider/facil Information used deral law.	ity will not condition treatment on whether or disclosed pursuant to this authorization	
ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.						
<ul> <li>If the patient is 18 years of age or older, the patient must sign and date the form.</li> <li>If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:         <ul> <li>Legal Guardian or Conservator</li> <li>Health Care Agent (Health Care Power of Attorney)</li> </ul> </li> <li>If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception</li> </ul>						
	exists under state or federal law. Please indicate your relationship:					
Signature (Required)  Date Signed (H				Date Signed (Red	quired) (Month DD, YYYY)	
	Printed Name of Person Signing (If Not Patient)  Mailing Address of Patient - Street					
	City		State	ZIP Code	Phone	