INTERNAL USE ONLY:
Medical Record # ________________ Account # V_____________________ AV #______________ ROI#_________

Moore County Hospital District
Health Information Management Department (Medical Records)
224 E 2nd Street | Dumas TX 79029
Phone: 806-935-7171 Fax: 806-935-3152

RELEASE OF PATIENT INFORMATION CONSENT FORM released from MCHD

Release Information to:____

Address: ____
City State Zip Code

Phone: ___________________________________ Fax: ___________________________________

Reason for Release: ____ personal ____ continued care other please describe ____________________

Please initial: ____________

I hereby authorize Moore Count Hospital District to furnish the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury. I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Moore County Hospital District in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization expires on the last day of the year it is signed. I further understand that I have a right to receive a copy of this authorization upon request.

Identifying Information:
Patient's Name at Time of Treatment: (Please Print)_____________________________________

Address: ____________________________City: ____________________ State: ______ Zip: _____________

Date of Birth: ____________________________ DL#____

Date of Treatment: _______________________________________ or if long term Beginning – Dec 31, 2020

Information Requested:

❑ Discharge Summary ❑ History and Physical ❑ Operative Report ❑ X-ray ❑ Consultation

❑ Clinical Laboratory ❑ EKG, EEG ❑ Progress Notes ❑ Other: _______________

Signed:____ ______________
Patient, Parent/Legal Guardian Date

____ ______________
Witness signature Date

Revised 10/2012, 5/2014, 6/2014, 1/2016, 12/2016, 11/9/17, 5/2018,1/1/19