Moore County Hospital District
Health Information Management Department (Medical Records)
224 E 2nd street
Dumas, TX 79029
Phone: 806-934-7850 Fax: 806-935-3152
MC.him@mchd.net

Disclosure Statement

I hereby authorize Moore County Hospital District to furnish the below-named individual or organization with all data and information they have requested as listed below concerning their illness, treatments, 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 terms as outlined above. I understand the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and it would no longer be protected by federal privacy regulations. I may revoke this authorization at any time 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 the authorization cannot be reversed and my revocation will not affect those actions. This authorization expires on the last day of the 3rd (third) year it is signed. I further understand that I have a right to receive a copy of this authorization upon request.

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____ / _____ / _____
- **Phone Number:** _____
- **Address:** _____

I hereby authorize the release of my medical records:

From:

- Name of Provider or Facility: _____
- Address: _____
- Phone: _____ Fax: _____

To:

- Name of Recipient (person, provider, attorney, etc.): _____
- Address: _____
- Phone: _____ Fax: _____

Type of Information to Be Released (Check all that apply):

☐ All Medical Records

☐ Office Visit Notes/Consultation/Progress Notes

☐ Labs and Test Results

☐ Radiology Reports / Images

☐ Billing Records

☐ Discharge Summary

☐ Other: _____

Dates of Service:

From _____ to _____

Purpose of Release:

☐ Continuation of Care

☐ Legal

☐ Insurance

☐ Personal

☐ Other: _____

Method of Delivery:

☐ Mail

☐ Fax

☐ Email (note: may not be secure)

☐ Pick-up

Authorization and Signature

I understand that:

- I may revoke this authorization at any time by submitting a written request.
- This authorization will expire as described in the disclosure above.
- Refusal to sign this form does not affect my ability to obtain treatment.
- I understand that my records may include sensitive information (mental health, HIV, drug/alcohol history) if I authorize release of such.

Patient Signature: _____ DL# or Valid ID _____

Date: _____

If not patient, name and relationship of representative:

- Name: _____
- Relationship: _____
- Signature: _____
- Date: _____

INTERNAL USE ONLY

MR#_____MC#_____AB#_____ ROI#_____