

**INTERNAL USE ONLY:**

Medical Record # \_\_\_\_\_ Account # V \_\_\_\_\_ AV # \_\_\_\_\_ ROI# \_\_\_\_\_



**Moore County Hospital District**  
224 E 2<sup>nd</sup> Street Dumas TX 79029

**Health Information Management Department (Medical Records)**  
Phone: 806-935-7171 Fax: 806-935-3152

**RELEASE OF PATIENT INFORMATION CONSENT FORM from other facilities to MCHD**

**REQUESTING DEPARTMENT: MOORE COUNTY HOSPITAL INTERNAL MEDICINE**

**ORTHO CLINIC OBGYN CLINIC MCFHC FOOT CLINIC SURGERY**

**Release Information From:** \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for Release: \_\_\_ personal \_\_\_ continued care other please describe \_\_\_\_\_

**Please initial:** \_\_\_\_\_

I hereby authorize \_\_\_\_\_ 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: \_\_\_\_\_ Social Security # \_\_\_\_\_ -- -- \_\_\_\_\_

DL# \_\_\_\_\_

Date of Treatment: \_\_\_\_\_ or if long term Beginning – Dec 31, 2017

**Information Requested:**

- Discharge Summary
- History and Physical
- Operative Report
- X-ray
- Consultation
- Clinical Laboratory
- EKG, EEG
- All Records
- Other: \_\_\_\_\_

**Signed:** \_\_\_\_\_ Date \_\_\_\_\_  
Patient, Parent/Legal Guardian

\_\_\_\_\_  
Witness signature Date