Austin Lakes Hospital closed effective 8-5-2022
Fax # 615-997-1200 Phone # 615-312-5834

UHS-NRO Records Dept. now handles all Release of Information Requests
Email: nrorecordsrequests@uhsinc.com
Address: 1000 Health Park Dr. Bldg. 3 Ste. 400 Brentwood, TN 37027

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Austin Lakes Hospital 1025 E. 32nd Street, Austin, Texas 78705
Phone: 512-544-8496 Fax: 512-544-8958

Patient Name:_____ Date of Birth:_____/____/_____

Address:_____

City:_____State:_____Zip:_____Telephone:_____

I hereby freely and voluntarily authorize Austin Lakes Hospital to (check box below): **Treatment Dates: To:_____ From:_____**

☐ **Release/disclose my protected health information to:** **OR** ☐ **Obtain my protected health information from:**

NAME:_____Relationship to Patient: _____

Address:_____City:_____State:_____Zip:_____

Telephone:_____ Fax:_____Email:_____

This information is necessary for: ☐ Follow-up Care ☐ Patient Request / Personal** ☐ Attorney / Legal** ☐ Disability Benefits**
☐ Other** (explain): _____ ****Indicates Fee for Service (Cost based on page count)**

Please disclose the following: ☐ Physician Progress Note(s) ☐ History & Physical ☐ Psychiatric Evaluation ☐ Psycho Social
☐ Discharge Summary ☐ Treatment Plan ☐ Medication List ☐ Lab Results ☐ Face sheet ☐ Leave of Absence Request
☐ Other (explain) _____

I give special permission to release any information regarding items listed below:

Alcohol, Drug, or Substance abuse Records	☐ **YES** ☐ **NO**	**INITIAL:** _____
HIV / AIDS Medical Information	☐ **YES** ☐ **NO**	**INITIAL:** _____
Psychotherapy Notes	☐ **YES** ☐ **NO**	**INITIAL:** _____

Please disclose my information via: ☐ **FAX** ☐ **MAIL** ☐ **PICK-UP** ☐ **VERBAL** _____

By signing this authorization, I understand that:

- Requests for copies of medical records are subject to **Fee for Service** in accordance with federal/state regulations.
- I have the right to **REVOKE** this authorization at any time. I can revoke this authorization during my stay, please specify below.
- After I discharge, revocation must be made in writing and presented to the Health Information Management Department at the following address: 1025 E. 32nd Street, Austin, TX 78705. Revocation will not apply to information that has already been disclosed in response to this authorization.
- This authorization will expire one year from the date signed unless otherwise specified (Otherwise specified date _____).
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure.
- Copy of driver's license or identification card must accompany all requests.

*******THIS AUTHORIZATION FORM IS ONLY VALID WHEN FULLY COMPLETED*******

_____ _____ _____ _____
Patient Signature or Authorized Representative (Guardian) *DATE* *TIME* *Relationship to Patient*

_____ _____ _____ _____
Witness *DATE* *TIME* *Relationship to Patient*

This Authorization has been revoked effective:

_____ _____ _____ _____
Patient Signature or Authorized Representative (Guardian) *DATE* *TIME* *Relationship to Patient*

_____ _____ _____ _____
Witness *DATE* *TIME* *Relationship to Patient*