Main Facility
551 HILL COUNTRY DRIVE
KERRVILLE, TEXAS 78028
(830) 896-4200

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize _____

_____

To release to: **PETERSON HEALTH**
Please fax to:
- ❑ Health Information Management/Medical Record Dept: 830-258-7489
- ❑ Emergency Dept: 830-258-7690
- ❑ Patient Experience Department: 830-258-7841
- ❑ Peterson Community Care Clinic: 830-258-7820
- ❑ Other Fax: _____

Attention to: _____

Purpose of the information request: Medical care at PETERSON HEALTH
- ❑ In Hospital ❑ In Emergency Dept ❑ INPT/OUTPT Surgery/Clinic
- ❑ Other: _____

INFORMATION ON:
PATIENT NAME _____
MAIDEN/OTHER NAMES _____
DATE OF BIRTH_____ **SOCIAL SECURITY #**_____
ADDRESS_____
_____**PHONE** _____

Medical Information Relating to:
- ❑ Visits/Dates of Service between _____ (date) and _____ (date).
- ❑ Medical conditions or Treatment Relating to: _____

_____

Information to be released:

___ H&Ps/Discharge Summaries/Consults	___ Radiology/Imaging Reports	___ Lab Reports
___ Operative & Pathology Reports	___ Radiology/Imaging film/CD	___ EEGs/Neuro Reports
___ Emergency Dept. Reports	___ Pulmonary Reports	___ Prenatal Record
___ Autopsy Report/Death Certificate	___ EKGs/Echocardiograms/Cardiopulmonary Tests	

___ Other _____

Per HIPAA regulations, no patient authorization is required for patient care or hospital operations (such as internal quality control and auditing).

_____ _____
Patient's Signature Date

_____ _____ _____
Patient's Legally Authorized Representative Relationship to Patient Date