**How do I complete the authorization form?**

* **Insert the name of the health-care facility you want to get a copy of your records from, (i.e., Sweeny Community Hospital).**
* **Insert the address of the facility (not necessary if for Sweeny Community Hospital). Put a check in the box beside the parts of the medical record you want. There is no charge for records if being used for continued medical care or for insurance purposes to get your claim paid. If you are getting records for other reasons, (i.e., legal, personal, non-medical reasons, etc.) there will be a charge if the number of pages is more than 10. If you are not sure which parts of the record you need, please call us. (NOTE: Please do not put “all records”, be specific.)**
* **Insert the name and physical address or email address of the person or facility to receive the copy of your medical record. If it is yourself, record your information.**
* **State the reason you need a copy of your record, (for example: continued care, file insurance claim, personal use, legal purposes, etc.).**
* **Insert the patient’s identifying information and the date(s) of treatment. If you are 18 or older and the request is for your own records, initial on line below “patient information” and sign your name at the bottom of page.**
* **Insert the date the form is signed.**
* **If the patient is under 18, a parent or guardian must sign the form, list the relationship to the patient and state the reason the patient cannot sign the form. Example: The patient is a minor and lives with his/her parents. One of the parents would sign the form, list “parent” as the relationship and state “minor child” as the reason the patient is unable to sign.**

**Who can sign the authorization?**

* **If the patient is an adult (18 or older), only the patient may sign the authorization. Neither spouses or parents of adult children may sign the authorization unless the patient has named them as their designated agent in a medical power of attorney and the patient is unable to sign.**
* **If the patient is a minor (under age 18, unless emancipated), parents may sign. If the parents are divorced, the divorce decree will be reviewed to see who is authorized to release medical information.**
* **If the patient has a legal guardian, guardianship papers may need to be reviewed.**
* ***Exceptions: Minors who seek treatment for pregnancy or sexually transmitted diseases must authorize the release of information themselves.***

**Return the completed form to Sweeny Hospital Medical Records Department**

* **Bring the form to the Sweeny Hospital Business Office Annex Building at the address below.**
* **Email the completed form and a copy of your photo ID to** [**medicalrecords@sweenyhospital.org**](mailto:medicalrecords@sweenyhospital.org)**. The records will be emailed back to you via an encryption process that will direct you to a secured site to retrieve the records.**

**What’s the fee for getting a copy of my medical record?**

**Ten pages are provided free. After that, the fee is 50 cents per page, which must be paid before the copies are released. There is no charge for records requested for continued medical care or for insurance purposes to get claim paid.**

**Where should I direct my questions?**

**Sweeny Community Hospital**  
**Medical Records Department**  
***206 N. McKinney***  
***Sweeny, TX 77480***

***Phone: (979) 548-1592***  
***Fax: (979) 548-5230***

**Office hours:**  
***Monday–Thursday 8:00 a.m.–5:00 p.m.***

***Friday 8:00 a.m. – 4:00 p.m.***

***Call (979) 548-1592***

***Email: medicalrecords@sweenyhospital.org***

**AUTHORITY TO REVIEW AND/OR RELEASE PROTECTED HEALTH INFORMATION**

AUTHORITY IS HEREBY GRANTED TO

(FACILITY RELEASING INFORMATION)

AT

(ADDRESS) (CITY) (STATE) (ZIP CODE)

TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME, SPECIFICALLY:

□ FACE SHEET □ BILLING RECORD □ HISTORY AND PHYSICAL □ DISCHARGE SUMMARY

□ DOCTOR’S ORDER □ OPERATIVE REPORT □ PROGRESS NOTES □ CONSULTATION REPORT

□ LAB REPORTS □ X-RAY REPORTS/FILM □ CARDIOPULMONARY REPORTS □ PATHOLOGY REPORT

□ ER RECORD □ EMS RECORD □ MEDICATION RECORDS □ DISCHARGE INSTRUCTIONS

□ ENTIRE RECORD □ ENTIRE RECORD EXCLUDING NURSES NOTES □ ADVANCED DIRECTIVES/DPOA, POA

□ OTHER

NAME OF PARTY TO WHOM THE INFORMATION IS TO BE RELEASED

STREET ADDRESS

CITY STATE ZIP CODE PHONE NUMBER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS

FOR THE FOLLOWING PURPOSE: □ LEGAL □ MEDICAL □INSURANCE □PERSONAL □WORK □ OTHER (DETAIL BELOW)

AND THAT PURPOSE ONLY

(**OTHER USE IS FORBIDDEN)**

DESIRED FORMAT ON WHICH TO RECEIVE RECORDS: PAPER DISC ELECTRONIC MAIL

PATIENT INFORMATION

|  |  |  |
| --- | --- | --- |
| NAME | | DOB |
| ADDRESS | | TELEPHONE # |
| APPROXIMATE  DATE OF SERVICE: | ***THIS SECTION FOR* DATE OF SERVICE FIN MED REC # # OF PAGES RELEASED**  ***STAFF USE ONLY*** | |

***→\_\_\_\_\_\_\_\_\_\_\_ By initialing I acknowledge and hereby consent to such, that the released information may contain alcohol/drug abuse treatment, alcohol/drug screen test results, psychiatric, HIV testing, HIV results, AIDs or sexually transmitted disease information.***

**I, the undersigned, have read the above and authorized the staff of Sweeny Community Hospital District to disclose such information as requested above. I understand that this authorization may be withdrawn by me in writing at any time except to the extent that information has already been released pursuant to this authorization. I understand that when this information is used or disclosed according to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, and any person who may have interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information. This authorization expires 180 days from the date signed below and covers only treatment(s) dates specified above.**

**Please provide picture I.D.**

SIGNATURE OF PATIENT DATE SIGNED

SIGNATURE OF LEGAL REPRESENTATIVE RELATIONSHIP REASON UNABLE TO SIGN

979-548-1592 SWEENY COMMUNITY HOSPITAL FAX 979-548-5230

305 N MCKINNEY

SWEENY, TX 77480 REVISED: 09-2025