SCOTTISH RITE

Steps to Request Medical Records

1. STOP - If you have a MyChart account, you can request medical records through your account and receive a FREE copy of the electronic records. Complete the **medical records request form** in the menu.
2. Complete all required fields (handwritten or electronically) in **Authorization to Disclose Health Information** to avoid delays in processing the application (incomplete forms will be returned)
3. Signatures can **only** be handwritten (electronic signatures are not accepted)
4. Attach a copy of the photo ID
5. Mail, fax, in-person delivery or email completed form and identification

Scottish Rite for Children
Health Information Management Department
Release of Information
2222 Welborn Street
Dallas, Texas 75219

Email: HIM_Main@tsrh.org
Phone: 214-559-7455
Fax: 214-559-7422

Hours of Operation:
Monday – Friday 8:00 a.m. – 4:30 p.m.

SCOTTISH RITE FOR CHILDREN **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**	**MRN# (staff only):**

PATIENT NAME: **DOB:** **PHONE NUMBER:**

2222 Welborn St., Dallas, TX 75219 Ph: 214-559-7455 Fax: 214-559-7422	5700 Dallas Pkwy., Frisco, TX 75034 Ph: 469-857-2075 Fax: 469-857-2076	3800 Gaylord Pkwy., Ste. 850 Frisco, TX 75034 Ph: 469-857-2075 Fax: 469-857-2076

I hereby authorize **SCOTTISH RITE FOR CHILDREN (SRC)** to disclose treatment/medical information about the patient listed above to:

PERSON / FACILITY NAME:

____

STREET ADDRESS:____________________________**CITY:**______________**STATE:**______**ZIP:**________

PHONE NUMBER:______________________________ **FAX NUMBER:**______________________________

CHECK TYPE OF INFORMATION AUTHORIZED TO BE DISCLOSED

NOTE--The appropriate box below must be checked to avoid delay of request. We will only disclose records specifically requested.

METHOD OF DELIVERY: ❑ Pick-up ❑ Mail ❑ Fax (Healthcare Organizations Only) ❑ MyChart ❑ Verbal Communication
❑ Email to: ______________________ ❑ Encrypted ❑ Unencrypted

(Information will be sent by encrypted unless I specify otherwise. By requesting unencrypted email, I acknowledge that there is some risk that health information could be accessed by a third party.)

ELECTRONIC MEDIA: ❑CD ❑USB/Flash Drive (flat rate) ❑ **PAPER COPY** (rate dependent on # of pages)

DATE(S) OF SERVICE :______________________**through**______________________

❑ Summary Abstract (Clinic Progress Note, H&P, Operative Note, Lab, Consult, Path, Radiology, Discharge Summary, Diagnoses/Procedure List)	❑ History & Physical	❑ Complete Medical Record
❑ Facesheet – Includes Demographics	❑ Discharge Summary	❑ Billing Record
❑ Coding Summary (Diagnoses/Procedures) and Facesheet	❑ OP/Procedure Report	❑ Peer Support (Parent Name/Phone #)
❑ Progress Notes (Clinic, Inpatient or Outpatient)	❑ Lab/Path Report	______________________
❑ Center for Dyslexia Evaluation/Assessment Reports	❑ Radiology Report	❑ Form/Letter/Other:
❑ Care and Treatment – VERBAL COMMUNICATION ONLY	❑ Radiology Image - CD	
	❑ Implant Records	______________________

FOR THE PURPOSE OF: ❑Personal Records ❑School ❑Military ❑Legal ❑ SSI/Disability ❑Other ______________________
❑ **At the request of the individual** ❑Continuity of Care; *if applicable*–Upcoming Appointment Date: ______________________

YOUR INITIAL IS REQUIRED FOR THE FOLLOWNG SENSITIVE INFORMATION REQUESTS:

❑ Genetic Info (including Genetic Test Results) **Initial**________	❑ Drug, Alcohol, or Substance Abuse Records **Initial**________
❑ Mental Health (NOT Psychotherapy Notes) **Initial**________	❑ AIDS/HIV Test Results and Treatment **Initial**________

I understand that:

- ✓ This authorization will remain in effect for 1 year from the date signed. I further understand that I may revoke this authorization at any time by notifying our main campus **Health Information Management (HIM) Department in writing at 2222 Welborn Street, Dallas, Texas 75219.**
- ✓ Any Protected Health Information (PHI) released before a revocation or cancellation request – this has been released in good faith and is now in the records of a healthcare entity or provider as previously authorized.
- ✓ PHI used or disclosed pursuant to this form may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law; and information received by SRC from another healthcare provider is subject to re-disclosure according to Chap 159, TX OCC 159.005(e) & HIPAA.
- ✓ SRC is not responsible for any misuse or disclosure made by a third party to whom I have authorized release of the PHI.
- ✓ I have the right to request or inspect or copy my PHI to be used or disclosed, as provided in CFR 164.524. I also understand that under HIPAA Privacy my access to PHI may be restricted if appropriate for my care and treatment. If I have questions about disclosures of my PHI, I can contact HIM Dept. at SRC.
- ✓ I can refuse to complete this authorization and if I do complete - I understand I do not have to provide a purpose for request of my PHI.
- ✓ There may be nominal charges for copying and sending these records. This will be discussed at the time I sign or turn in this request.
- ✓ Authorizing the disclosure of PHI is voluntary and that my (my child's) healthcare treatment/eligibility for benefits will not be affected if I do not sign form.
- ✓ The information in my (my child's) health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, alcohol, or drug abuse, and/or social and family related matters. Psychotherapy notes recorded by a mental health professional documenting or analyzing conversation during a counseling session are maintained separately. Such information is subject to special protections pursuant to state and federal laws and regulations.

❑ **ID Type (Staff Only):**______________________
❑ **Request Fulfilled:** Date__________ Initials______

______________________________ ______________________
Signature of Patient or Personal Representative **Date**

______________________________ ______________________________
Print Name of Patient or Personal Representative **Relationship of Personal Representative's Authority**

CR0020