

**PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION  
TO COVENANT HEALTH SYSTEM LUBBOCK  
FROM \_\_\_\_\_**

PATIENT NAME: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
MEDICAL RECORD NO. \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_  
TREATMENT PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release information related to the treatment of the above named patient to Covenant Health System \_\_\_\_\_. This patient is currently being treated by the above named physician or organization: \_\_\_\_\_  
Name Address

**INFORMATION TO BE RELEASED:**

Any and all records, not to exclude drug, alcohol and other defined illnesses: \_\_\_\_\_

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> History & Physical  | <input type="checkbox"/> Microscopic Sides               | <input type="checkbox"/> Discharge Summaries  |
| <input type="checkbox"/> Diagnostic Findings | <input type="checkbox"/> Previous Radiation Records      | <input type="checkbox"/> Physical Therapy     |
| <input type="checkbox"/> Operative Notes     | <input type="checkbox"/> Port Films                      | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Program Plans       | <input type="checkbox"/> Physical Therapy Evaluation     | <input type="checkbox"/> Speech Therapy       |
| <input type="checkbox"/> Consultations       | <input type="checkbox"/> Occupational Therapy Evaluation | <input type="checkbox"/> Medical              |
| <input type="checkbox"/> Lab Work Results    | <input type="checkbox"/> Speech & Language Evaluation    |   |
| <input type="checkbox"/> Pathology Report    | <input type="checkbox"/> Psychological Evaluation        |   |
| <input type="checkbox"/> Films               | <input type="checkbox"/> Other: _____                    |   |

**INFORMATION RELEASED FOR CONTINUED MEDICAL CARE**

This consent will expire one hundred eighty (180) days after the date below or sooner, at my election.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Parent/Legal guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

COVENANT HEALTH SYSTEM  
LUBBOCK, TEXAS  
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