Sweeny Police Department

John Barnard, Chief of Police

PATIENT'S AUTHORIZATION FOR REVIEW OR RELEASE OF MEDICAL RECORDS

CUSTODIAN OF RECORDS: _____
(Hospital, Doctor's Office, E.M.T., Etc.)

CUSTODIAN'S ADDRESS: _____

PATIENT'S NAME: _____ **DOB:** _____ **SSN:** _____

PATIENT'S ADDRESS: _____ **PHONE:** _____

****

You are hereby authorized to allow _____ who is an officer with the Sweeny Police Department:

☐ To be furnished a copy of the complete hospital/medical records of the above named patient;

☐ To review and make a copy of the hospital/medical records of the above named patient pertaining to: _____ covering the period from _____ to _____.

The following records shall be released for **LEGAL** or **INTERNAL** purposes only in regards to a criminal investigation or internal investigation. These records may be used as evidence in a court of law in this county or another.

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. ***Please Initial Here*** _____.

I, the undersigned, have read the above and authorized the staff of _____ to disclose such information as requested above. I understand that this authorization may be withdrawn by me at any time except to the extent that information has already been released pursuant to this authorization.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 an 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.

_____ _____
Signature of Patient Date Signed

_____ _____ _____
Signature of Legal Representative (if minor) Relationship Reason Unable to Sign

Dispatch: (979) 548-3111
Admin.: (979) 548-3112
123 N. Oak Street
Sweeny, Texas 77480-2445
Fax: (979) 548-3326
www.sweenypolice.org