

AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR MENTAL HEALTH INFORMATION
Mayhill Hospital is now closed as of 09/2025



Mayhill Hospital

2809 S Mayhill Rd, Denton, TX 76208
Telephone: 940-239-3086 Fax: 940-239-3032

To prevent delay in processing your request, please include a copy of a government issued photo ID (i.e. a driver's license) for verification of signature.

Custodian of Records for closed facilities:
Universal Health Services
Nashville Regional Office
Phone: 615-312-5834
Fax: 615-997-1200
Email: nrrecordsrequests@uhsinc.com

I authorize the Mayhill Hospital to **release** _____ medical information concerning:
Patient Name _____ Date of Birth _____ Soc. Sec. No. _____
Address _____ Dates of Service _____
City _____ State _____ Zip _____ Telephone Number _____

This information is to be released to:

Name _____
Address _____
City/State _____ Zip _____ Telephone # _____

Please initial all boxes below that pertain to your condition. If it is not checked and initialed, and it pertains to your information, this release of information will not be honored.

Please release the following information, indicated by an "X":

- | | | |
|---|--|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation | <input type="checkbox"/> Assessment |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Radiology Results | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medications | <input type="checkbox"/> Other _____ |

- I give special permission to release any information regarding items listed below **INITIAL**
- | | |
|--|-------|
| <input type="checkbox"/> HIV Information | _____ |
| <input type="checkbox"/> Medical Information | _____ |
| <input type="checkbox"/> Psychiatric | _____ |
| <input type="checkbox"/> Substance Abuse Records | _____ |

This information is necessary for the following purposes:

___ Follow-up Care ___ Patient is requesting disclosure ___ Disability Benefits ___ Attorney or Legal
___ Other Please Explain _____

Please release my information via: Email/Fax/Mail (please provide) _____

The patient or the patient's representative must read the following statements:

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date _____). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, Mayhill Hospital can no longer use or disclose my information for the above purposes without a new authorization.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

I understand any of the above requested information may include results of sexually transmitted diseases; acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

SIGNATURE of Patient or Authorized Party Date RELATIONSHIP to Patient

WITNESS _____ REASON Patient is Not Signing _____