

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Who are you requesting records from? (Facility/Doctor) **NOT Vital Chart, enter the responsible medical facility or doctor's office.

Facility Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____

Whose records are you requesting? (Patient)

First Name: _____ Last Name: _____ Date of Birth: _____
SS# (last 4 digits): _____ Cell Phone: _____ Email Address: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date(s) of Treatment: _____

Who are you sending your records to?

First Name: _____ Last Name: _____
Fax: _____ Cell Phone: _____ Email Address: _____
Street Address: _____ City: _____ State: _____ Zip: _____

What information should be released?

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Complete Chart | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Blood Type | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Abstract/Basics |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> ER Records | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> EKG/ECHO |
| <input type="checkbox"/> Operative Record | <input type="checkbox"/> Other _____ | | | |

Why is this information being released?

- | | | | | |
|--|------------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> Patient Request | <input type="checkbox"/> Insurance | <input type="checkbox"/> Attorney | <input type="checkbox"/> Social Security | <input type="checkbox"/> Treatment/Consultation |
| <input type="checkbox"/> Other _____ | | | | |

SUBSTANCE USE/ABUSE TREATMENT, PSYCHIATRIC, GENETIC TESTING, AND/OR HIV/AIDS RECORDS RELEASE

Federal and State law requires specific authorization from patients to release sensitive information. I understand that if my medical or billing record contains information in reference to drug, tobacco and/or alcohol use/abuse, psychiatric care, genetic testing, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I must specifically agree to its release by checking Yes or No in the appropriate box. (TX HB 300)

- | | | | |
|-------------------------|--|---|--|
| Substance use or abuse: | <input type="radio"/> YES - Disclose | Psychiatric Care/mental health records: | <input type="radio"/> YES -Disclose |
| | <input type="radio"/> NO - Do NOT Disclose | | <input type="radio"/> NO - Do NOT Disclose |
| Genetic Testing: | <input type="radio"/> YES - Disclose | HIV/AIDS testing and/or treatment: | <input type="radio"/> YES -Disclose |
| | <input type="radio"/> NO - Do NOT Disclose | | <input type="radio"/> NO- Do NOT Disclose |

TIME LIMIT & RIGHT TO REVOKE

I understand this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new. Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address.

I desire this authorization to be in effect until _____ (expiration date/event).

AUTHORIZATION & RE-DISCLOSURE

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign this authorization form. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize the medical facility to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

Signature of Patient

Date