# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**I hereby authorize:** _____ (Facility Name)

_____ (Facility Address)

_____ (Facility City/State/Zip)

**To Release To:** _____(Recipient Name)

_____(Street Address)

_____(City, State, Zip)

Telephone Number_____ Fax No._____

**The following information from the medical record of:**

Patient Name: _____(first, last) Date of Birth:_____(mm/dd/yyyy)

Social Security No: _____-_____-_____ Date(s) of Treatment: _____

Patient Address: _____ Telephone: _____

**Information to be released:**

| | | | |
|---|---|---|---|
| □ Discharge Summary | □ History & Physical | □ Operative Record | □ Pathology Report |
| □ Laboratory Reports | □ Consultation Reports | □ EKG/ECHO | □ Blood Type |
| □ ER Records | □ Progress Notes | □ Radiology reports | □ Radiology films/CD |
| □ Complete Chart | □ Abstract/Basics | □ Face Sheet | □ Itemized Bill |

□ Other (specify):_____

**The information specified above is to be released for the following purpose:**

□ Treatment/Consultation □ Patient Request □ Billing or Claims □ Attorney □ Social Security

□ Other (specify) _____

**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 treatment… | □ YES-Disclose | □ NO-Do not Disclose. |
| Psychiatric Care and/or mental health records… | □ YES-Disclose | □ NO-Do not Disclose. |
| Genetic Testing… | □ YES-Disclose | □ NO-Do not Disclose. |
| HIV/AIDS testing and/or treatment… | □ YES-Disclose | □ NO-Do not Disclose. |

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

**Authorization and 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.

**Preferred method of Reproduction:** □ CD □ Paper - We will try to accommodate preference where practicable.

_____ _____

**Signature of Patient or Legal Representative** **Date**

_____

**Authority to sign if not Patient** (Documentation may be required)