# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.**

**NAME OF PATIENT OR INDIVIDUAL**

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____Day _____Year_____

ADDRESS _____

_____

CITY _____STATE_____ZIP_____

PHONE (____) _____ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

**I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

Person/Organization Name _United Regional Health Care System/Physicians Group
Address _____
City _____State _____Zip Code_____
Phone:(940)764-3627 Fax (940)764-3355

**WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?**

Person/Organization Name _____
Address_____
City _____
Phone (_____)_____Fax (_____)_____

**REASON FOR DISCLOSURE**

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

**Dates of Service Requested**:
From_____ To: _____

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

| | | | |
|---|---|---|---|
| ☐ **Hospital Records** | ☐ **URPG Records** | ☐ ER Records | ☐ Lab Results |
| ☐ All Health Information | ☐ History/Physician Exam | ☐ Operation Reports | ☐ Immunizations |
| ☐ Physician Orders | ☐ Patient Allergies | ☐ Diagnostic Test Reports | ☐ Consultation Reports |
| ☐ Progress Notes | ☐ Discharge Summary | ☐ Radiology Reports/Images | ☐ EKG/Cardiology Reports |
| ☐ Pathology Reports | ☐ Billing Information | ☐ Physical Therapy | ☐ Other _____ |

**Your initials are required to release the following information:**

____ Mental Health Records (excluding psychotherapy notes)
____ Drug, Alcohol, or Substance Abuse Records
____ Genetic Information (Including Genetic Test Results)
____ HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code §181.154(c) and/or 45 C.F.R. §164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE X**_____ _____

**Signature of Individual or Individual's Legally Authorized Representative** **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, 3e.g., Tex. Fam. Code 32.003).

**SIGNATURE X**_____ _____

**Signature of Minor Individual** **DATE**