

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

All Sections Must be Completed for Valid Authorization

Patient's PRINTED Name: _____ Birth Date: _____ Social Security No. _____

Street Address: _____ City, State: _____ Home Phone #: _____ Work Phone #: _____

I hereby authorize _____ (Hospital) to disclose records obtained in the course of my evaluation and /or treatment to: _____ (Name and address of person or organization to which disclosure is to be made)

Name: _____ Address: _____
City: _____

Phone #: _____ Fax #: _____

Type of Access Requested: _____ Copies of Record OR _____ Inspection of records OR _____ Release to Media/Marketing
Medical Record Requested: (Entire Record or Selected Portions of PHI as marked below) (recording, filming, interview, photo)

<input type="checkbox"/> Std Dr Office Set	<input type="checkbox"/> Rehab Services	<input type="checkbox"/> Nurses Notes	Billing Records:	
<input type="checkbox"/> Discharge Summary	Type _____	<input type="checkbox"/> Progress Notes		
<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Lab	<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Detailed Bill
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Imaging/Radiology	<input type="checkbox"/> Pathology Report		<input type="checkbox"/> UB 92 (Forward Copy to PAD for Processing)
<input type="checkbox"/> Consult Report(s)	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Entire Medical Record		<input type="checkbox"/> Other _____
<input type="checkbox"/> Operative Reports (s)	<input type="checkbox"/> Medication Record	<input type="checkbox"/> Other _____		

_____ (Initials) I Do or I Do Not consent to released information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV testing, HIV (AIDS) testing and/or results, genetics information, or such disclosure shall be limited to the following specific types of information:

List the purpose(s) (including marketing) for the release or disclosure of Protected Health Information: _____

Will the recipient receive financial or in kind compensation in exchange for using or disclosing the information? Yes** No
** If yes, describe the type of compensation: _____

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the Hospital's Health Information Management/Medical Records Department for assistance at () - .

This Consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:
Expiration Date: _____ or
Expiration Event: _____ None: _____, or define: _____

- I understand that:
- Information disclosed by this authorization may be re-disclosed by the recipient of my PHI . Such re-disclosure will no longer be protected by this authorization.
 - I have the right to receive a copy of this authorization. Copy of the authorization received. _____(Initials)
 - A copy or facsimile (fax) of this authorization is as valid as the original.
 - My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.
 - Mammography films are part of the permanent medical record, and must be maintained at the facility according to Texas state guidelines. Films requested by, or on behalf of, the patient, should be returned to CLRMC, Breast Diagnostic Center.

I hereby release _____ (Hospital) from any and all legal liability and injuries that arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. Mail Service and /or electronic facsimile in accordance with Hospital's facsimile (fax) policy.

I have read the above or have had it read to me and authorize the disclosure of the protected Health Information as stated.

SIGNED: _____ DATE: _____

(Signature of Patient/Legal Guardian or Representative*)
If signed by other than patient, indicate relationship: _____

Witness: _____ DATE: _____

**Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*

To the Party Receiving this Information:

This information has been disclosed to you from records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.

FOR OFFICE USE ONLY

Completed By: _____ Date Completed: _____ Copy sent to Pad (date): _____

Medical Record #: _____ Account#: _____