AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security #_____(optional)

I authorize the following individual or organization to disclose the above named individuals health information:

_____ Address _____

This information may be disclosed TO and used by the following individual or organization:

_____ Address _____

For the purpose of: _____

Please release the following: {Note: list not required by HIPPA}

____Entire Record

Or:

____Problem List
____Progress notes
____History/Physical Exam
____Medication List
____Immunization Record
____List of Allergies
____X-Ray/Imaging Reports-from (date)_____to (date)_____
____X-Ray Films
____Laboratory Results-from (date)_____to (date)_____
____EKG Reports
____Genetic Testing Information
____Other Diagnostic Reports (Specify)
____Other (Specify)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about, behavioral or mental health services, treatment for alcohol and drug abuse, and genetic testing.

____**Yes**, I consent to the release of this information. ____**No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact_____(insert privacy officer or other office or individuals name or contact information)

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to of Patient if Legal Representative Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical record may contain reports, test, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold_____ liable for any misinterpretation in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to of Patient if Legal Representative Witness

Date request completed_____ # of pages copied _____ Reviewed only _____
Charges $_____ Cash_____ Check #_____ Initials_____

*[All articles and any forms, checklists, guidelines, and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor constructed as establishing medical standards of care for the purposes of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted – with the advice of the organization's attorney – to meet state, local, individual organizations and department needs or requirements. They are distributed wit the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services]