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| **AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION** |
| This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual’s protected health information. Individuals completing this form should read the form in its entirety before signing and complete all sections that apply to their decisions relating to the use or disclosure of their protected health information. |
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| Patient’s Name: | Date Of Birth: |  |
| Address: | City: | State: | Zip: |
| Phone: |  | Email (optional): |
| Information regarding health care provider or health care entity authorized to disclose this information: |
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| Sending Physician/Practice: Fredericksburg Clinic | Phone: 830-997-2181 | Fax: 830-997-4453 |
| Address: 1308 South State Hwy 16 | City: Fredericksburg | State: TX | Zip: 78624 |
| Information regarding person or entity who can receive and use this information: |
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| Receiving Physician:  | Phone:  | Fax: |
| Address:  | City:  | State:  | Zip:  |
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| Information to be disclosed: |
| [ ] Medical Records from to [ ] Entire Medical Record(except psychotherapy notes) |
| [ ] Other (Please list)  |
| I authorize the above named facility to include the following in my medical records:  |
| [ ] Drug, Alcohol, or Substance Abuse Records [ ] Mental Health Records (except Psychotherapy notes) [ ] Genetic Information |
| [ ] HIV/AIDS-Related Information (Including HIV/AIDS Test Results) |
| Reason for release of information (Choose all that apply): |
| [ ] Continuing Medical Care [ ] Personal Use [ ] Billing or Claims [ ] Insurance [ ] Legal Purposes [ ] Disability Determination |
| [ ] School [ ] Employment [ ] Other (Please Specify) |
| The Individual signing this form agrees and acknowledges as follows: |
| * This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
* I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
* This authorization may include disclosure of information relating to **Drug, Alcohol** and **Substance abuse, Mental Health Information,** except psychotherapy notes, **Confidential HIV/AIDS-Related Information,** and **Genetic Information** only if I check the appropriate boxes above. In the event the health information described above includes any of these types of information, and I check the corresponding box above, I specifically authorize release of such information to the person or entity indicated herein.
* I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of heath information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.
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| Signature of patient or Personal Representative (If not patient please list relationship) Date: |
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| Signature of Minor (If applicable): Date: |
| A minor’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. |