

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I. PATIENT INFORMATION:

Patient Name:		
Date of Birth:		
Patient Mailing Address:		
City:	State:	Zip:
Work #:	Home #:	Cell #:
My family physician is:		

II. INFORMATION TO BE DISCLOSED:

I authorize _____ to disclose my health information as follows, for service dates: _____:

- | | |
|---------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> All paper chart records | <input type="checkbox"/> All electronic medical records |
| <input type="checkbox"/> Entire medical record/outpatient clinical record | <input type="checkbox"/> Laboratory results |
| <input type="checkbox"/> History and physical(s) | <input type="checkbox"/> Radiology and imaging reports |
| <input type="checkbox"/> Operative report(s) | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Discharge summary(ies) | <input type="checkbox"/> Other test results: _____ |
| <input type="checkbox"/> Films and pictures | <input type="checkbox"/> Other: _____ |

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION IS TO BE DISCLOSED TO/FROM:

Disclose to:	Disclose from:

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Houston Methodist Primary Care Group.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by the federal privacy laws.
- I understand that Houston Methodist may disclose my Protected Health Information electronically or by other means

Signature of Patient or Qualified Personal Representative*

Date

*If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: _____

Legal Documentation showing Authority to Act on Behalf of the Patient: _____

(Example: Guardian of Patient, Executor of Estate)