HOUSTON HEALTHCARE

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section 1. Patient Information
I hereby authorize the use or disclosure of the individual identifiable health information as described below. I understand this authorization is voluntary.

Patient Name:	Patient Date of Birth:			Copy of Identification
Patient Social Security No. (optional):	Patient Telephone:			
Patient Address:	City:	State:	Zip:	

Section 2. This will authorize the use/disclosure of the patient's protected health information to the following individual or entity:

Name:	Telephone Number:		
Name	Fax Number:		
Address:	City:	State:	Zip:

Section 3. Purpose of use or disclosure of the protected health information:
☐ At the request of the individual (patient) or ☐ Other_____

Section 4. I understand this authorization is valid for 90 days from today's date and will expire at that time unless another date is written here _____

Section 5. Description of information to be used or disclosed: The information used/disclosed pursuant to this authorization may include information relating to mental health, HIV, AIDS, alcohol or substance abuse, or sexually transmitted disease. This information will not include psychotherapy notes kept by the patient's psychiatrist or psychotherapist. The entire medical record request will not include items in bold print.

Description:	Service Date(s):	Description:	Service Date(s):
☐ Ambulance Record		☐ Immunization Record	
☐ Cardiac Cath Report		☐ Laboratory Test Results	
☐ Cardiac/Pulmonary Rehab		☐ Medication Records	
☐ Consultation Reports		☐ Med-Stop Record	
☐ Discharge Summary Report		☐ Mental Health Records	
☐ ECG/EKG Reports		☐ Occupational Health & Wellness	
☐ Emergency Room Record		☐ Operative Report	
☐ Entire Medical Record* Will not include items in bold print.		☐ Pathology Report/Microscopic Slides	
☐ Financial Billing Record – Summary UB-04 ☐ Financial Billing Record – Itemized Request from the Business Office (478) 975-5244		☐ Physical/Occupational/Speech Therapy (PT/OT/ST Records)	
		☐ Radiology Reports	
		☐ Radiology Images	
☐ History and Physical Report		☐ Other – Specify	

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary. I understand I may inspect the information to be used/disclosed if I request.
2. I may revoke this authorization at any time by presenting my revocation in writing. The revocation is only effective after it is received and logged by the Health Information Management Department. Any use or disclosure made prior to revocation is not included as part of the revocation.
3. I understand treatment is not conditioned on signing this authorization.
4. I understand the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by federal privacy regulations.
5. Houston Healthcare and its employees and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Section 6. Signatures

I have read the above and authorize the use/disclosure of the protected health information as stated. This authorization must be signed and dated by the patient or the patient's legal representative. A patient's legal representative must include a description of the representative's ability to act on behalf of the patient and any document providing such authority i.e. Power of Attorney, Guardianship, Court Order.

Signature of Patient/Guardian/Patient's Legal Representative	Printed Name	Today's Date

As a legal representative, my relationship to the patient is _____. Any document providing such authority must be attached. The patient is unable to sign because _____.

Contact the Health Information Management Department for Houston Healthcare-Warner Robins and Houston Healthcare-Perry at 478-542-7748 for questions related to this authorization.

For Facility Use Only

Medical Record #: _____ Date Authorization Received: _____ Date Release Authorization Scanned or Documented in System: _____

Date Information Disclosed: _____ Person Sending the Information Requested: _____