AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Adapted from Texas Attorney General's Office
Developed for Texas Health & Safety Code §181.154(d)

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code §181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorizations is not required for disclosures related to treatment, payment, healthcare operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

1. Patient Information

First Name **Last Name** **MI**

Date of Birth: _____

Address: _____

_____

City: _____

State: _____ **ZIP Code:** _____

Phone (Cell): ( ) -

Phone (Home): ( ) -

Phone (Work): ( ) -

2. Authorization for Release

Please only check (✓) one option below.

❑ **I authorize the following to disclose the individual's protected health information:**

McAllen PCI: Preventive Care Institute
500 S. Bicentennial Blvd.
McAllen, Texas 78501
Phone: (956) 971-0077 / Fax: (956) 971-0076

❑ **I *DO NOT* authorize the disclosure of the individual's protected health information.**

3. Reason for Disclosure of Records:

Please only check (✓) one option below.

- ❑ Treatment/Continuing Medical Care
- ❑ Personal Use
- ❑ Billing or Claims
- ❑ Insurance
- ❑ Legal Purposes
- ❑ Social Security Benefits
- ❑ Disability Determination
- ❑ School
- ❑ Employment
- ❑ Other: _____

4. Who can receive and use my information?

Please fill out at least one of the two slots below.

1. Person / Organization: _____
Address: _____
City: _____ **State:** _____ **ZIP:** _____
Phone: _____ **Fax:** _____
Email (Optional): _____

2. Person / Organization: _____
Address: _____
City: _____ **State:** _____ **ZIP:** _____
Phone: _____ **Fax:** _____
Email (Optional): _____

5. What information may be disclosed?

Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ❑ All health information
- ❑ Physician's Orders
- ❑ Progress Notes
- ❑ Pathology Reports
- ❑ History/Physical Exam
- ❑ Patient Allergies
- ❑ Discharge Summary
- ❑ Billing Information
- ❑ Past/Present Medications
- ❑ Operation Reports
- ❑ Diagnostic Test Reports
- ❑ Radiology Reports & Images
- ❑ Lab Results
- ❑ Consultation Reports
- ❑ EKG/Cardiology Reports
- ❑ Other: _____

6. Medical Record Fee (If Applicable):

Please be aware that for producing and completing certain medical record requests PCI holds the right to charge a reasonable fee (this only applies to a record request that exceeds 25 pages); the base fee is $25.00; any additional pages will be priced at $0.50 each. For clarification regarding these fees or to see if a fee may be imposed upon your request please seek assistance from the front desk.

If you understand and accept these fees that may be imposed please sign under, "Signature of Patient or Legal Representative," upon completion of this form.

7. Your initials are required to release the following information listed below:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

8. **EFFECTIVE TIME PERIOD:** This authorization is valid until the earlier of the occurrence of: (1) the death of the individual; (2) the individual reaching the age of majority; (3) permission is withdrawn, or (4) the following specific date: _____.

9. **RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "**Who can receive and use my information**?" I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

10. **SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code §181.154(c) and/or 45 C.F.R. §164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature of Patient or Legal Representative: _____ **Date:** _____

PRINTED NAME OF LEGALLY AUTHORIZED REPRESENTATIVE (if applicable): _____

If representative, specify relationship to the individual: _____ Parent of minor / _____ Guardian / _____ Other: _____

A minor individual'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, drug/alcohol/substance abuse, and mental health treatment. (See Texas Family Code §32.003).

Signature of Minor Individual: _____ **Date:** _____

**********OFFICE USE ONLY**********

I have confirmed that the "AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION" form has been completed in its absolute entirety – no further information regarding the release of records is needed at this time.

Staff Signature: _____ **Date:** _____

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