

AUTHORIZATION FOR USE, REQUEST AND DISCLOSURE OF PROTECTED HEALTH INFORMATION



Patient Information:

Patient Name: _____
Medical Record Number or _____
Social Security Number: _____
Date of Birth: _____

Address: _____
City/State: _____
Zip: _____
Phone No.: _____

I hereby authorize Harris Health System or _____ to release and provide copies of the information indicated below to the following entity/person:

Name of Entity/Person: _____
Phone No.: _____
Address: _____

City/State: _____
Zip Code: _____

Check this box if the above named entity or person(s) to receive copies of your health care information is requesting your records for you (e.g., your attorney or your personal representative)

Information To Be Released – Covering the Periods of Health Care:

From (date): _____ To (date): _____

Facility:

- All Harris Health Facilities Ben Taub Hospital Lyndon B. Johnson Hospital Quentin Mease Hospital
 Clinic(s): _____

Please check type of information to be released:

- Complete Medical Record
 [OR the records marked below]
- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Emergency Room Record(s) | <input type="checkbox"/> Operative/Procedure Report(s) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clinic Visit(s) | <input type="checkbox"/> Entire Inpatient Record | <input type="checkbox"/> Pathology Report(s) | _____ |
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Entire Outpatient Record | <input type="checkbox"/> Pathology Slides/Blocks | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Image(s) | |
| <input type="checkbox"/> Eligibility Record(s) | <input type="checkbox"/> Lab Report(s) | <input type="checkbox"/> Radiology Report(s) | |
| | <input type="checkbox"/> Psychotherapy Notes (No other boxes maybe checked, if this box is checked) | | |

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand and agree that the information requested may contain reference(s) to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information.

Format:

- Paper Compact Disc (CD)

Purpose of Request/Disclosure:

- Treatment or Consultation Legal Government Benefit Request of Patient Billing/Insurance/Claims Other: _____

Expiration of Authorization:

This authorization will automatically expire in 180 days from the date of the signature unless: (1) an expiration event or date is provided below; or (2) "none" has been entered when this authorization is for the purpose of research only.

This authorization expires on _____ (Expiration date or event, e.g., discharge from hospital or delivery of requested information).

Withdrawal/Cancellation of Authorization:

I understand that this authorization may be withdrawn or cancelled by me or my personal representative by written and dated notice to Harris Health System. To withdraw or cancel this authorization, written and dated notice must be sent to: Harris Health System's, Office of Corporate Compliance at: Office of Corporate Compliance, Attn: Privacy Officer, 2525 Holly Hall, Ste. 171, Houston, Texas 77054. The withdrawal or cancellation of this authorization will not change any of the releases of information that were made before my withdrawal or cancellation. Please see Harris Health System's Notice of Privacy Practices for more information.

Potential Re-Disclosure:

I understand that once my information is disclosed, it may be re-disclosed by the recipient and no longer protected by state and federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule).

I understand that I do not have to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits at Harris Health System will not be denied if I do not sign this authorization.

Signature of Patient (or Patient's Personal Representative)

Date

Name of Patient (or Personal Representative) (Print)

Personal Representative's Relationship to Patient

Witness Signature

TO BE COMPLETED BY HARRIS HEALTH SYSTEM:

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____

This document contains protected and confidential patient health information and must be secured at all times while in use. Immediately dispose of in the blue recycling bin when done using the document.