HARRISHEALTH SYSTEM

Authorization for Release of Information

Media, Marketing and Educational Use

I hereby authorize the Harris Health System to use or disclose the following information. This authorization is voluntary and Harris Health System will not be making payments of any kind. If I refuse to participate, my refusal will not affect my ability or that of my dependent(s) to receive health care from Harris Health System. I understand Harris Health System IS NOT receiving payment of any kind from any source for the use of my information. I understand that once my information is disclosed, it may be re-disclosed by the recipient and no longer protected by federal or state privacy laws. I hereby release Harris Health System, its governing board, administrators, employees and affiliating physicians from any legal liability for disclosure of my health information or that of my dependent(s) as permitted by this authorization.

A Harris Health System representative or designee fills out the shaded area as directed by the patient or patient's representative:

Patient's Name: ____ D/O/B: __________

Address: ____________________________________ City: ________________ State: ________

Telephone: _________________________ Medical Record Number: ______________________

Information to be released – Covering the period of healthcare:
From (Date) ___________________________ To (Date) ______________________________

Date of release expiration (*if desired*): ____

Type of patient information: *Check where appropriate*
Nature of injury or illness: ____ Nature of treatment: ____ Recordings (*Any and all recordings, including, but not limited to videotapes, photographs, or electronic, digital or audio recordings*): _____
If other, please explain: ____

Reason for request: *Check where appropriate*
Media: _____ Marketing: _____ Educational: _____ If other, please explain: ____________________

My health information may be disclosed to:
Name:___________________________ Organization/Media: ___________________________

Drug and Alcohol Use, Psychiatric, and/or HIV/AIDS Information Release:
I understand that this information may contain reference(s) to drug and/or alcohol use, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information and I specifically authorize its release. *Check one*: Yes_____ No _____

Expiration/Withdrawal of Authorization:
This authorization will expire on December 31, ______ (20 years from the year this document was signed), unless the patient is a minor, in which case this authorization will expire when the patient turns 18 years of age. I understand that this authorization may be revoked by me or my personal representative by written and dated notice. To withdraw, I will write to: Harris Health System HIM/Medical Records, Authorization Withdrawal P.O. Box 66769, Houston, TX 77266--6769.

Signature: ____ Date: ___________________________

Witness: ____ Date: ___________________________

If a personal representative signs on behalf of the individual, complete the following:

Representative's Name: ___________________________ Relationship: ________________________

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