Authorization to Release Health Information

HENDRICK HEALTH

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Dates of Service_____

I hereby authorize _____ to **obtain** true and correct copies of the health care information (including any and all individually identifiable health information under HIPPA regulations) identified below pertaining to the history, diagnosis, treatment or prognosis of the Patient below. **(Select Facility) ___HMC ____HMCB ____HMCS ____Other** _____

PATIENT INFORMATION (please print)			
Last Name:	First Name:	Date of Birth:	Last 4 of SSN:
Release Information via: ❑ Personal Pickup	❑ Mail Address:	❑ Fax Number:	❑ Email:

PLEASE RELEASE THE FOLLOWING INFORMATION:			
❑ **All health information****	❑ History/Physical Exam	❑ Past/Present Medications	❑ Lab Results
❑ Physician's Orders	❑ Patient Allergies	❑ Operation Reports	❑ Consultation Reports
❑ Progress Notes/Office Visits	❑ Discharge Summary	❑ Diagnostic Test Results	❑ EKG/Cardiology Reports
❑ Pathology Reports	❑ Billing Information	❑ Radiology Reports & Images	❑ Fetal Heart Strips
❑Other:			

**** Your initials are required to release the following information:**

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

REASON FOR DISCLOSURE (Choose only ONE option below)		
❑ Treatment/Continuing Medical Care	❑ Personal Use	❑ Billing or Claims
❑ Insurance	❑ Legal Purposes	❑ Disability Determination
❑ School	❑ Employment	❑ Other:

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

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 persons or organizations noted below "WHO CAN RELEASE, DISCLOSE, RECEIVE, AND USE THE HEALTH 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.

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

I AUTHORIZE THE FOLLOWING TO RELEASE AND DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION (PHI):			LIST WHO CAN RECEIVE AND USE THE PROTECTED HEALTH INFORMATION (PHI)		
Person/Organization Name: Hendrick Service Center			Person/Organization Name:		
Address: 4310 Buffalo Gap Rd, STE 2000			Address:		
City: Abilene	State: TX	Zip: 79605	City:	State:	Zip:
Phone: 325-670-2407	Fax: 325-670-6538		Phone:	Fax:	

SIGNATURE AUTHORIZATION

_____ Signature of Individual or Individual's Legally Authorized Representative	_____ Printed Name of Legally Authorized Representative (if applicable)
_____ Date Signed	Relationship to Patient: ❑ Parent of Minor ❑ Legal 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, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ Signature of Minor Individual	_____ Printed Name of Minor Individual
_____ Date Signed	

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