AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Texas healthcare providers: *The Texas Medical Records Privacy Act requires the Attorney General of Texas to adopt a standard Authorization to Disclose Protected Health Information form. Download the form at www.texasattorneygeneral.gov/consumer-protection/health-care/patient-privacy.*

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

Date of birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
(Healthcare provider) (Address, street, city, state, zip code)

to release to: _____
(Persons/organizations authorized to receive the information) (Address, street, city, state, zip code)

a. The following information is to be released:
   - ☐ Entire record – Date(s) of service: _____
   - ☐ Assessment/history and physical – Date(s) of service: _____
   - ☐ Discharge summary – Date(s) of service: _____
   - ☐ Lab tests – Date(s) of service: _____
   - ☐ Radiology reports – Date(s) of service: _____
   - ☐ Other (please specify needed information and date[s] of service if known): _____

b. I specifically authorize the release of the following information (check as appropriate):
   - ☐ Mental health treatment information[1] (A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)
   - ☐ HIV test results
   - ☐ Alcohol/drug treatment information
   - ☐ Genetic information/testing

Patient's Initials

_____ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

_____ I understand my treatment or payment for my treatment cannot be conditioned on signing this authorization.

_____ This authorization remains valid for two years from the date of signature.

_____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

PURPOSE

The purpose of the release of this information is:

☐ Insurance or other third-party reimbursement
☐ Continuity of care*
☐ Pending legal action
☐ At the request of the patient
☐ Other (Specify): _____

*If for continuity of care, records needed for appointment on _____.
(Date and time)

RESTRICTIONS

According to federal and state regulations, if the health information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the health records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release _____ (Name of healthcare provider) and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____
(Name and address of practice)

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and no longer protected by the HIPAA Privacy Rule.

SIGNATURES

Patient or Legal Representative Signature/Date/Time

Print Patient's or Legal Representative's Name

Legal Representative's Relationship to Patient

Witness Signature/Date/Time

Print Witness's Name

1. (California only) If the patient requests mental health information covered by the Lanterman-Petris-Short Act be released to a third party, the healthcare practitioner, who is in charge of the patient must approve the release. If the release is not approved, the reasons should be clearly documented. (Note: The patient, however, could most likely legally obtain a copy of the record himself or herself and provide the records to the third party.)

2. If any of the HIPAA-recognized exceptions to this statement applies, this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.