

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT/RESIDENT IDENTIFICATION

PRINT Patient Name (Last Name, First Name)

Date of Birth

Mailing Address

Social Security Number

Phone Number

INFORMATION TO BE RELEASED

_____ I authorize the release of my: Complete Health Record **ONLY**.

_____ I authorize the release of the following sections of the medical record.

Please place an "X" in the box(es) that apply to the information to be released (if not requesting the complete medical record.)

- | | | |
|--|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Medications / Immunizations | <input type="checkbox"/> Billing Record & Statements | <input type="checkbox"/> Diagnosis & Treatment Codes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Photographs or Video | <input type="checkbox"/> Consult Reports |
| <input type="checkbox"/> Laboratory Reports | | |
| <input type="checkbox"/> Other, specify _____ | | |

The Purpose of this Authorization is indicated in the box(es) below.

Please place an "X" in the box(es) that apply.

- | | |
|--|---|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Changing Physicians or Consultation | <input type="checkbox"/> Research or Research Related Treatment |
| <input type="checkbox"/> Billing or Claims Payment | |
| <input type="checkbox"/> Other, specify _____ | |

WHO AND WHERE TO SEND/RELEASE INFORMATION

PRINT Name

Email Address

Address

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

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check one:** Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check one:** Yes No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, at any time I can revoke this Authorization by submitting a notice in writing to the facility Privacy Officer at One Riverway, Suite 700, Houston, Texas 77056. Unless revoked, this Authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION *(continued)*



Re-disclosure

I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its team members, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated authorized herein.

Signature of Patient/Resident or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this Authorization, and my treatment or payment for services will not be denied if I do not sign the form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Nexus Health Systems to use and disclose the protected health information specified above.**

PRINT Patient/Patient Representative Name

Relationship

Signature of Patient/Patient Representative

Date

Basis of Authority (e.g., Legal Guardian, Power of Attorney, Conservator)

Signature of Staff Witness

Date