AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION –TX HIM.PRI.010

Section A: This section must be completed for all Authorizations (Texas)

Provider's Name & Address:
Heart Hospital Of Austin
3801 N. Lamar Blvd.
Austin, Texas 78741

Phone Number: (512) 407-7660
Fax Number: (512) 407-7665

Office Use: MR#_____

Encounter #_____

____ Faxed _____ Mailed ____ Picked Up

Date:_____ # of Pages _____

Patient Name:

Date of Birth:

Social Security No. ***(optional)*:**

Recipient's Name & Address:

Phone Number:

Fax Number:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**
Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
All PHI in medical record		Operative Report		Cardiac Rehab Packet	
History and Physical		Cardiac Cath Report		Radiology Reports	
Discharge Summary		Special test/therapy		Imaging Film/CD	
Physician Orders		Rhythm Strips		Itemized bill:	
Progress Notes		Laboratory Reports		UB-92:	
Consultation Report		Pathology Reports		Heart Saver CT	
Medication Sheets		ER Information		Other: _____	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

If this authorization is for disclosure of genetic information, please describe: _____

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? Yes No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:

Date:

Print Name of Patient's Representative:

Relationship to Patient: