Authorization To Disclose Protected Health Information

Patient's Full Name: _____ Date of Birth: _____

Address: _____

City, State, Zip _____

Patient's Phone No. _____ Alt Phone _____

REASON FOR DISCLOSURE (Choose only One Option Below)

☐ Continued Patient Care ☐ Personal Use ☐ Attorney/Legal ☐ Other _____

I authorize the following to Disclose the individual's protected Health Information

_____

Dr or Facility Name

_____

Address

_____

City, State & Zip

_____

Phone # **Fax #**

Who can receive and Use the health information

Ramsey Pediatric Center

27700 Northwest Freeway Suite 250

Cypress, Texas 77433

Phone 281-469-4378 Fax 281-469-7355

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box

☐ **All Health Information** ☐ Progress Notes ☐ Lab/Radiology Reports

☐ Immunization Records ☐ Growth Chart ☐ Medical Summary ☐ Other _____

Your Initials are required to release the following information:

____Mental Health Records _____Drug, Alcohol, or Substance Abuse Records ____ HV/AIDS Test Results/Treatment

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This Authoriation will expire on the 180th day of the signing unless a lesser date is specified here:_____

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 person or organization named under "WHO CAN 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

Signature _____ _____

Signaute of Individual or Individual's Legally Authorized Representative **Date**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ___ Parent of minor ___ 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 _____ _____

Signaute of Minor Individual **Date**