AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

For the Disclosure of Protected Health Information Pursuant to 45 CFR § 164.508(a)(1)

Patient's Name: ____

Home Address: ____

____

Home Telephone: ______________________ Alt. Number: ______________________

Social Security No.: ______________________ D.O.B. ______________________

Covering the Periods of Health Care from (date) ______________ to (date) ______________

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes: (Check all that apply)

___ Discharge Summary	___ Lab Results	___ ER Note	___ Review Only ______
___ History & Physical	___ X-ray Reports	___ EKG	___ Blood Type ______
___ Consultation	___ Operative Report	___ Anesthesia Record	___ Complete Record

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about psychiatric, mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

Description of protected health information to be disclosed:

In-patient and/or out-patient records; admission/discharge records; consent forms; authorization forms; patient questionnaires; patient history and/or physical forms; operative reports; physician's notes; nurse's notes; physician orders; observation notes; procedure notes; physical therapy records; rehabilitation records; fact sheets; lab reports; summaries; photographs; slides; pulmonary or cardiac diagnostic test reports; consultation reports; progress reports; status reports; diagnoses; treatment reports; narratives; emergency room records; x-rays; CT scans; MRI scans; EEGs; EKGs; echocardiogram reports and tapes/films; V/Q scans and/or lung scan reports; and tapes/files; sonogram or ultrasound reports; arteriogram reports; cardiac catheterization reports; pathology reports; written prescriptions; autopsy reports; post-mortem reports; external examination reports; toxicology reports; body transferal records; billing invoices; handwritten notes; office notes; patient charts; test results or data; psychological reports; mental health records;

THIS AUTHORIZATION IS INTENDED TO APPLY ONLY TO WRITTEN RECORDS AND DOES NOT AUTHORIZE ANY VERBAL DISCUSSIONS CONCERNING MY MEDICAL CONDITION OR TREATMENT WITH ANYONE REGARDING THE ABOVE REFERENCED RECORDS. Specifically, no verbal discussions may be held concerning my past or present medical condition or treatment unless such verbal communications are made in the presence of my attorneys, ______________________________. (See Mutter v. Wood, 744 S.W.2d 600 (Tex. 1988) and McGown v. O'Neil, 750 S.W.2d 884 (Tex. App.-Houston [14th Dist.] 1988, no writ)).

Person(s) or class of persons authorized to disclose the protected health information:

All "Covered Entities" and their "Business Associates" as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). On and after September 1, 2003, this authorization shall also authorize disclosures of protected health information by "Covered Entities" and their "Business Associates" as defined under Chapter 181 of the Texas Health & Safety Code.

By signing this Authorization, I understand that I am giving my authorization to designated medical record custodians or database custodians ____ to use and/or disclose my protected health information as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Henjum Goucher Reporting Services, L.P.
2501 Oak Lawn Ave., Suite 435
Dallas, Texas 75219
tel.(214)521-1188
fax(214)521-1034

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the ________ day of _______________, 200__.
☐ Until ____ fulfills this request.
☐ Until the following event occurs: ____.
☐ Other: ____.

I understand that I may revoke this authorization in writing at any time. I understand that I may revoke this authorization by sending or faxing a written notice to the disclosing party identified above. This written revocation must state my intent to revoke. I understand that many actions already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions.

I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), psychiatric, alcohol, and drug abuse records; the protected health information described above may be re-disclosed and is no longer protected by federal and state privacy regulations. I understand that the entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. **This Authorization is voluntary and I may refuse to sign this Authorization. Any facsimile or copy fo this authorization shall be as valid as the original. Furthermore, I understand that I am entitled to, and must receive, a signed copy of this authorization.**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize ____ to use or disclose my health information in the manner described above.

Signature of Patient: ____ Date: __________________

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized Personal Representative: ____

Printed Name of Authorized Personal Representative: ____

Relationship to Patient: _________________________

Date: ____________________