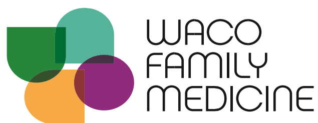

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Waco Family Medicine ◦ 1600 Providence Dr ◦ Waco, TX 76707

Patient Name: ________________________________ Date of Birth: __________________ SS #: ________________________

Address: ____________________________ Apt # _____ City: _____________________State: ______ Zip Code: ___________

Obtain Information From:

Name: ____

Address: ____

City: _________________ State: _______ Zip Code_______

Ph #: _____________________ Fax #: _________________

Release Information To:

Name: ____

Address: ____

City: ____________________ State: _______ Zip Code________

Ph #: _____________________ Fax #: ____________________

PATIENT INFORMATION IS NEEDED FOR THE FOLLOWING:

O Transfer Care O Treatment O Insurance O SS Disability
O Legal Purposes O School/Daycare O Personal Use O Other, please specify ___________________________

Dates of Treatment: ____

Information to Be Used and/or Disclosed:

O Face Sheet O History and Physical O Office Notes O Lab/Pathology Reports O Operative Reports
O Consultation Reports O X-ray Reports Other (Specify) ____

Substance Abuse, Mental Health, HIV/AIDS

I understand that my medical or billing records might contain information in reference to drug, alcohol, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/Aids (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), and/or other sensitive information and I agree to this release. _______

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 Office at **1600 Providence Dr, Waco, TX 76707.** Unless revoked, this authorization will expire on the following date or event: ___________________________ or one year after the date of the signing of this authorization as shown below.

Re-Disclosure

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

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that Waco Family Medicine may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Waco Family Medicine to use and disclose the protected health information described above.

Signature: ____ Date: ____________________________________

Patient or Legally Authorized Representative

____ ____

Printed Name of Patient or Legally Authorized Representative Relationship to Patient

Fees/Charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at the time of release.