

ENT for Children, P.A.

## Authorization for Release of Protected Health Information

**NAME of PATIENT**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Other (Preferred) Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

Person/Organization Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
**WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?**  
 Person/Organization Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**REASON FOR DISCLOSURE**  
 (select only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other \_\_\_\_\_

**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.

<input type="checkbox"/> All health information	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Past/Present Medications	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Patient Allergies	<input type="checkbox"/> Operation Reports	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnostic Test Reports	<input type="checkbox"/> EKG/Cardiology Reports
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Billing Information	<input type="checkbox"/> Radiology reports/images	<input type="checkbox"/> Other _____

**Your initials are required to release the following information:**

\_\_\_\_ Mental Health Records (excluding psychotherapy notes) \_\_\_\_\_ Genetic Information (including Genetic Test Results)  
 \_\_\_\_\_ Drug, Alcohol, or Substance Abuse Records \_\_\_\_\_ HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): \_\_\_\_\_ (MM/DD/YYYY)

**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 laws.

SIGNATURE X \_\_\_\_\_  
 Signature of Individual or Individual's Legally Authorized Representative

DATE \_\_\_\_\_

Printed Name of legally Authorized Representative (if applicable): \_\_\_\_\_  
 Specify relationship to the individual:  Parent of minor  Legal 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.

SIGNATURE X \_\_\_\_\_

Signature of Minor Individual

DATE \_\_\_\_\_

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**Fees to Copy Records:** \$25 for the first 20 pages of medical records copied, \$0.50 for each additional page plus postage. No charge for records sent to another physician.

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**Definitions:** In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

**Health Information to be Released:** If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502)

**Note on Release of Health Records:** This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

**Charges:** Some covered entities may charge a retrieval/processing fee for copies of medical records. (Tex. Health & Safety Code § 241.154).

**Right to Receive Copy:** The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.