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**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure**

**NAME OF PATIENT OR INDIVIDUAL**

**of protected health information. Covered entities as that term is**

**defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual’s legally authorized representative to electronically disclose that individual’s protected health information.**

**OTHER NAME(S) USED**

**DATE OF BIRTH Month** Day Year

**ADDRESS**

**CITY STATE ZIP PHONE** ( ) **ALT. PHONE** ( )

**EMAIL ADDRESS** (Optional):

**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**

**(Choose 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.

|  |  |  |  |
| --- | --- | --- | --- |
| * **All health information**
 | * History/Physical Exam
 | * Past/Present Medications
 | * Lab Results
 |
| * Physician’s Orders
 | * Patient Allergies
 | * Operation Reports
 | * Consultation Reports
 |
| * Progress Notes
 | * Discharge Summary
 | * Diagnostic Test Reports
 | * EKG/Cardiology Reports
 |
| * Pathology Reports
 | * Billing Information
 | * Radiology Reports & Images
 | * 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 permission is withdrawn.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described.

 **SIGNATURE X**

**DATE**

**Signature of Individual or Individual’s Legally Authorized Representative**

 Printed Name of Legally Authorized Representative (if applicable):

If representative, specify relationship to the individual:  Parent of minor  Guardian  Other

**Charges** - Some covered entities may charge a retrieval/processing fee and for copies of medical records.

(Tex. Health & Safety Code § 241.154).

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**Dallas, Texas 75206**

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