AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below. I understand that medical information is considered Protected Health Information (PHI) under both Federal and State Privacy Laws. I also understand there may be a fee for copy services rendered. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

1. Patient Name (please print)	2. Date of Birth	3. License Identification
4. Address (Street, City, State, Zip Code)		5. Telephone Number

6. Your health information may be disclosed to and used by the following: (check all that apply)

☐ Self ☐ Physician/Hospital ☐ Insurance Company ☐ Legal Representative ☐ Other (spouse, relative, etc.)

Name: _____

Address: _____

7. **Method of Release/Disclosure:**

☐ **Mail** ☐ **Pick up** ☐ **Verbal Disclosure** ☐ **Fax:** _____

☐ **encrypted CD** ☐ **encrypted email (print email address):** _____

8. Treatment dates:	9. Purpose of Request:

At which hospital did you receive care? (choose one)

☐ **Arise Austin Medical Center**

☐ **The Hospital at Westlake Medical Center**

The following information is to be disclosed: (please check all that apply)

- ☐ Complete Record
- ☐ Discharge Summary
- ☐ History & Physical Examinations
- ☐ Consultations
- ☐ Operative and/or Procedure Reports
- ☐ Cardiac Cath Lab
- ☐ Emergency Department Record
- ☐ Physician Progress Notes
- ☐ Physician Orders
- ☐ Radiology Reports
- ☐ Radiology Images (CD or Films) please circle
- ☐ Laboratory Reports
- ☐ Nursing Notes
- ☐ Medication Records
- ☐ Billing Records
- ☐ Other _____

Expiration: Unless otherwise revoked, this authorization will expire in 6 months (180 days) from the date of my signature. Otherwise, specified date of expiration: _____

Redisclosure: If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

Please Initial and Sign Below:

Initial: _____ Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

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Initial: _____ Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information already released based on this authorization.

Signature of Patient or Authorized Party: **Date:**

_____ ____ /____ /____

_____
Print Name of Patient or Authorized Party: (and relationship to Patient, if necessary)