Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Print Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Information to be Released- Covering the Periods of Health Care

From (date): _____ To (date): _____

Please check type of information to be released:

__ Complete Health Record	__ Diagnosis & Treatment Codes	__ Discharge summary
__ History and physical exam	__ Consultation reports	__ Progress Notes
__ Laboratory test results	__ Radiology reports/ images	__ Cardiac imaging
__ Photographs, Videotapes	__ Complete billing records	__ Itemized bill
__ Discharge Instructions	__ Pulmonary function results	__ Immunization record
__ Release of Information (ROI) Abstract- History & Physical (H&P), Discharge Summary, Operative Report, Procedure Note, Consultation, Laboratory, Pathology, X-Ray reports.		
__ Other (specify) _____		

Purpose of Request

__ Treatment or consultation	__ At the request of the patient	__ Billing or claims payment
__ Other (specify) _____		

Send / Release Information

___ Paper ____ CD ___ Electronic Portal (E-mail notification when access is available)

***Please initial if you have requested your information to be sent to you in an unencrypted electronic format _____.**

Release to Name: _____

Mail to Name: _____

Mail to Address: _____

E-mail Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and/or psychiatric treatment I have been afforded the opportunity to sign a specific authorization. *Initial One:* Yes _____ No _____ Not Applicable _____

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.

Initial One: **Yes_____** No_____ **Not Applicable ____**

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 John A. Evans M.D., 423 Treeline Park Suite 350, San Antonio, TX 78209. Unless revoked, this authorization will expire 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and 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 I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize John A. Evans M.D. to release the protected health information specified above.

Signature: _____ Date: _____

Authority of Personal Representative to Request Disclosure: _____

Identity of Requestor Verified via: ____ **Photo ID ____ Matching Signature ___ Other, specify _____**

Verified by: _____