Permission to Communicate
Authorization for Use and Disclosure of Protected Health Information

Patient Name: ______________________________ Date of Birth: ______________

Home Address: ______________________ City: ______________ State: _____ Zip: ________

Home Telephone #: (______) ______________ Cell Telephone #: (_____) ____________________

Period of Healthcare of information to be released: From: (date) __________ To: (date) ______________

Type of Information to Be Released (Please check only those that apply)

- ❒ Complete health record
- ❒ History and physical exam
- ❒ Laboratory test results
- ❒ Photographs, videotapes
- ❒ Diagnosis and treatment codes
- ❒ Consultation reports
- ❒ X-ray reports
- ❒ Complete billing record
- ❒ Discharge summary
- ❒ Progress Notes
- ❒ X-ray films / images
- ❒ Itemized bill
- ❒ Other (please be specific): ____

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

Initial One:

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and treatment, that I have been afforded the opportunity to sign a specific authorization.

_____ Yes _____ Not Applicable

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

_____ Yes _____ Not Applicable

I decline the specific authorization:

_____ **Yes** ______ **No**

Purpose of Request:

- ❒ Treatment or Consultation
- ❒ At the request of the patient
- ❒ Billing or Claims Payment
- ❒ Other (please be specific): ____

Individual(s) Authorized to Send/Release Information:

Name: ______________________________ Relationship: ____________________

Date of Birth: ______________________ Phone Number: ____________________

Name: ______________________________ Relationship: ____________________

Date of Birth: ______________________ Phone Number: ____________________

Except to the extent that action has already been taken in reliance on this authorization, I can, at any time, revoke this authorization by submitting a notice in writing to the Privacy Officer at *HealthTexas Medical Group of San Antonio*. Unless revoked or otherwise indicated below, this authorization will expire on **December 31, 2031**.

Expiration date ________________ (enter a specific date – “indefinite” or “forever” are not acceptable)

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.

I understand that I do not have to sign this authorization, and my treatment or payment of 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 the release of this information to any *HealthTexas Medical Group of San Antonio* facility which may need the information for treatment, payment or healthcare operations.

I authorize *HealthTexas Medical Group of San Antonio* to release the protected health information specified above.

Signature:____Date:______________

Signing Authority (if not patient):________________________Relationship: ______________

Identity of Requestor Verified via: ❒ Photo ID ❒ Matching Signature ❒ Other (specify):________________

Verified by:________________________Printed Name:________________________

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