Form 1021 – Authorization for Use and Disclosure of Protected Health Information

Patient Identification – Please Print

Full Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: TX _____ Zip: _____

Home Telephone #: _____ Mobile Telephone #: _____

Information To Be Released – Covering the Periods of Healthcare

Facility: _____ Phone: _____

Address: _____ Fax: _____

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

Type of Information To Be Released – Please check only those that apply

❒ Complete health record ❒ Photographs, videotapes ❒ X-ray reports ❒ Progress Notes

❒ History and physical exam ❒ Diagnosis and treatment codes ❒ Complete billing record ❒ X-ray films / images

❒ Laboratory test results ❒ Consultation reports ❒ Discharge summary ❒ Itemized bill

❒ Other (please be specific): _____

Purpose of Request

❒ Treatment or Consultation ❒ At the request of the patient ❒ Billing or Claims Payment

❒ Other (please be specific) _____

Who and Where to Send/Release Information

Attn: HealthTexas Medical Group (❒) OR - Other (Please Specify) (❒) _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

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	❒ 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 that I have been afforded the opportunity to sign a specific authorization.	❒ Yes	❒ No	❒ Not Applicable
I decline the specific authorization.	❒ Yes	❒ No	❒ Not Applicable

Time Limit and Right to Revoke Authorization

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, this authorization will expire on the following date or event _____, or 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 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 receive 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 _____