

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)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Photographs, videotapes | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Diagnosis and treatment codes | <input type="checkbox"/> Complete billing record | <input type="checkbox"/> X-ray films / images |
| <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Itemized bill |
| <input type="checkbox"/> Other (please be specific): _____ | | | |

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 treatment, that I have been afforded the opportunity to sign a specific authorization.

Initial One: _____
____ 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, 2030**.

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: _____