

Authorization for Use or Disclosure of Protected Health Information FROM Austin Thyroid & Endocrinology

ATE MRN

Patient Information

Patient Full Name: Date of Birth: Patient Address: Home Phone: City: State: Zip: Work Phone:

Release Information To:

I hereby authorize Austin Regional Clinic (ATE) to release my medical record information to:

Mail Copies To: Hold for Patient Pickup: Discuss Medical Information with: Electronically Deliver To:

Name/Facility: Attention:

Address: Phone:

City: State: Zip: Fax: Email:

Purpose of Request: Personal, Continuing Care, Insurance, Legal, Transfer Out, Other

Information to be Released:

- Please provide a 2 year abstract... Other - Please be specific...

Comments

Authorization to Release Protected Information

*Required - Please complete the check boxes indicating how protected information should be handled Release Records? Check One Initial below to confirm your choice

I DO DO NOT want my Entire Record released.

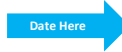
I understand that if I check that I want my Entire Record released, all records created in the course of my treatment... will be released.

If you DO NOT want your Entire Records released, please check what you would like excluded:

Mental Health Treatment, HIV Tests, Genetic Testing, Hepatitis C Tests, Alcohol and/or Substance Abuse

I specifically authorize ATE to disclose my Protected Health Information as described on this form to the recipients listed above.

I understand ATE is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or healthcare operations.



Patient's Signature

Date*

Parent/Legally Recognized Representative Signature**

Date**

Witness

Date

Know your Privacy Rights Refer to HIPAA "PRIVACY NOTICE"

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise...

**By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following...

1CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2)...