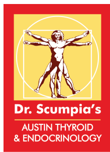

Authorization for Use or Disclosure of Protected Health Information FROM Austin Thyroid & Endocrinology

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 Thyroid & Endocrinology (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 (second opinion or refer to specialist) ◯ Insurance ◯ Legal
◯ Transfer Out (Reason? ______________________)
◯ Other ______________________________

Information to be Released:

◯ Please provide a 2 year abstract (includes 5 years of diagnostics) - Copy fee capped at $25.00 for a 2 year abstract
◯ Other – Please be specific, include dates and providers under comments.
Note: You will be invoiced according to the TX Statute Copy Fee: Please see the ATE Release of Information Fee Explanation.

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 on the date(s) listed above, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, genetic testing information, and communicable disease status, including AIDS/HIV, will be released.

If you **__DO NOT__** want your Entire Records released, please check what you would like excluded:

☐ **Mental Health Treatment** ☐ ***HIV Tests & Related Information** ☐ ***Genetic Testing Information**
☐ ***Hepatitis C Tests & Related Information** ☐ ***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 that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth 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. I have read the authorization and understand what information will be used or disclosed, who may use and disclose this information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization. ATE reserves the right to disclose information electronically for treatment, payment, or healthcare operations, unless otherwise required by law.

____
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: You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that ATE has already completed action on it.

**By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: The information released pursuant to the Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws.

[1]**CONFIDENTIALITY 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). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.