# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Patient Identification**

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone: (_____) _____

**Information to be Released – Covering the Periods of Health Care**

From (date) _____ To (date) _____

***Please check type of information to be released:***

| | | |
|---|---|---|
| ☐ Complete health record | ☐ Diagnosis & treatment | ☐ Discharge summary |
| ☐ History and physical exam | ☐ Consultation reports | ☐ Progress notes |
| ☐ Laboratory test results | ☐ X-ray reports | ☐ X-ray films / images |
| ☐ Photographs, videotapes | ☐ Complete billing record | ☐ Itemized bill |

☐ Other, (specify) _____

**Purpose of Request**

| | | |
|---|---|---|
| ☐ Treatment or consultation | ☐ At the request of the patient | ☐ Billing or claims payment |

☐ Other, (specify) _____

**Who and Where to Send / Release Information**

Name: _____

Address: _____

_____

## 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, and/or psychiatric, I have been afforded the opportunity to sign a specific authorization. ***Initial One: 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 I have been afforded the opportunity to sign a specific authorization. ***Initial One: Yes*** _____ ***No*** _____ ***Not Applicable*** _____

**Time Limit & Right to Revoke Authorization**

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 865 Deshong Dr., Paris, TX 75460. 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 off 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 for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or receive a copy of the protected health information to be used or disclosed.
**I authorize Paris Regional Medical Center to release the protected health information specified above.**

Signature: _____ Date: _____ Authority to Sign if Not Patient: _____

Identify of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: _____

Paris Regional Medical Center

ROI