

Hand delivered authorizations are accepted at the facility where services were provided - Note: Include copy of valid photo ID with Authorization

All sections must be completed for a valid authorization.

Patient Name:	Birth Date:	Last 4 Digits SSN (optional):
Patient Alias(s):	Patient Contact Number:	
Recipient's Name:	Recipient's Phone:	Recipient's Fax:
Recipient's Address (City, State, Zip):		

Request Delivery (If left blank, a paper copy will be provided): Paper Copy Electronic Media, if available (e.g., USB drive, CD/DVD)
 Encrypted Email Unencrypted Email
 NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

Purpose of disclosure:

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>
<input type="checkbox"/> Abstract (most common) <input type="checkbox"/> Clinical Test(s) <input type="checkbox"/> ER Information <input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Operative Documentation <input type="checkbox"/> Physician Dictated Reports		<input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Entire medical record <input type="checkbox"/> Other: _____		Confidential Information <input type="checkbox"/> HIV Testing <input type="checkbox"/> HIV & AIDS Documentation <input type="checkbox"/> Psychiatric Documentation <input type="checkbox"/> Alcohol & Drug Abuse Documentation	

I hereby authorize the Hospital marked below to release records to the recipient party designated above.

Below marked HCA Houston Healthcare Facility:

<input type="checkbox"/> Clear Lake	<input type="checkbox"/> Medical Center	<input type="checkbox"/> Southeast	<input type="checkbox"/> Corpus Christi Medical Center (+ Campuses)
<input type="checkbox"/> Conroe	<input type="checkbox"/> Northwest	<input type="checkbox"/> Specialty Hospital MC	<input type="checkbox"/> Rio Grande Regional Hospital
<input type="checkbox"/> Kingwood	<input type="checkbox"/> North Cypress	<input type="checkbox"/> Tomball	<input type="checkbox"/> Texas Orthopedic Hospital
<input type="checkbox"/> Mainland	<input type="checkbox"/> Pearland	<input type="checkbox"/> West	<input type="checkbox"/> The Woman's Hospital of Texas
			<input type="checkbox"/> Valley Regional Medical Center

This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:

Expiration Date: _____ **or** **Expiration Event:** _____

- I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary
 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
 5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
 6. I get a copy of this form after I sign it.

Unless I specifically mark below that I do not consent, I am expressly consenting to the release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, genetic information, or such disclosure shall be limited to the following specific types of information: I DO NOT CONSENT []

Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? Yes No

If yes, the health plan or health care provider must complete below, otherwise skip to signature.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? Yes No

If yes, describe: _____

May the recipient of the PHI further exchange the information for financial remuneration? Yes No

I have read the above or had it read to me and I authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Patient's Representative:	Date:
---	--------------

Print Name of Patient's Representative:	Relationship to Patient:
--	---------------------------------

*Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.

Identification Verified by: _____ State Issued Photo Identification Other: _____