

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**I. PATIENT INFORMATION:**

Patient Name:		
Date of Birth:		
Patient Mailing Address:		
City:	State:	Zip:
Work #:	Home #:	Cell #:
My family physician is:		

**II. INFORMATION TO BE DISCLOSED:**

I authorize \_\_\_\_\_ to disclose my health information as follows, for service dates: \_\_\_\_\_:

- |   |   |
|---|---|
| <input type="checkbox"/> All paper chart records                          | <input type="checkbox"/> All electronic medical records |
| <input type="checkbox"/> Entire medical record/outpatient clinical record | <input type="checkbox"/> Laboratory results             |
| <input type="checkbox"/> History and physical(s)                          | <input type="checkbox"/> Radiology and imaging reports  |
| <input type="checkbox"/> Operative report(s)                              | <input type="checkbox"/> Pathology reports              |
| <input type="checkbox"/> Discharge summary(ies)                           | <input type="checkbox"/> Other test results: _____      |
| <input type="checkbox"/> Films and pictures                               | <input type="checkbox"/> Other: _____                   |

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

**III. INFORMATION IS TO BE DISCLOSED TO/FROM:**

Disclose to:	Disclose from:

**IV. PURPOSE OF USE OR DISCLOSURE:** \_\_\_\_\_

**V. I authorize the disclosure of health information as described above. I understand:**

- This authorization is valid for 180 days unless otherwise stated here: \_\_\_\_\_
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Houston Methodist Surgical Associates.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by the federal privacy laws.
- I understand that Houston Methodist may disclose my Protected Health Information electronically or by other means

\_\_\_\_\_  
**Signature of Patient or Qualified Personal Representative\***

\_\_\_\_\_  
**Date**

\*If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: \_\_\_\_\_

Legal Documentation showing Authority to Act on Behalf of the Patient: \_\_\_\_\_  
 (Example: Guardian of Patient, Executor of Estate)