Authorization for Use and Disclosure of Protected Health Information

Patient Identification:
Printed Name: _____ Date of Birth: _____

Address:_____

Social Security #:_____ Telephone #: _____
PURPOSE OF DISCLOSURE as described here:
☐ Review Only ☐ Marketing: _____
☐ Release of Medical Records Is this release for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items, ☐ No, then you may check as many items as you need.
Information to Be Released/Accessed – Covering the Periods of Health Care
From (date): _____ **To (date):** _____
☐ **Other (specify):** _____

☐ Complete Health Record	☐ Diagnosis & Treatment Codes	☐ Discharge Summary
☐ History and Physician Exam	☐ Consultation Reports	☐ Progress Notes
☐ Laboratory Test Results	☐ X-Ray Reports/Films/Images	☐ Physician Orders
☐ Photographs, video	☐ Complete Billing Record	☐ Transfer Forms

Payments to Facility:
This marketing activity involves direct or indirect compensation/payments from a third party to **The Hospitals of Providence** for this use of protected health information. Check One: _____Yes _____ No If Yes, describe_____
Who and Where to Send/Release Information
Name: _____

Address: _____

Fax Number: _____

DRUG AND/OR ALCOHOL ABUSE, AND/OR HIV/AIDS RECORDS RELEASE
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or sensitive information, I have been afforded the opportunity to sign a specific authorization.
INITIAL ONE: YES_____ NO_____ NOT APPLICABLE_____

I understand if my medical or billing record contains information in references to HIV/AIDS testing and/or treatment. I have been afforded the opportunity to sign a specific authorization.
INTITAL 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 11274 McCombs Street, Suite 100, El Paso, TX 79934**. **Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.**

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 and Portability and Accountability Act of 1996, and other Federal Privacy regulations. The Facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of 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, and it is strictly voluntary. I can inspect or copy the protected health information to be used or disclosed. **I authorize The Hospitals of Providence to use and disclose the protected health information specified above.**

Signature Pt/Pt's Representative:_____ Date: ____/____/____ Time: _____

Print Name of Signature/Relationship if not the patient: _____

Identity of Requestor Verified via: _____Photo ID____Matching Signature _____ Other, Specify_____

Verified by/Witness: _____ Date: _____/_____/_____ Time: _____

The Hospitals of PROVIDENCE