Mission Regional Medical Center

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

NAME OF PATIENT:_____
Last First Middle

OTHER NAME(S) USED: _____

DATE OF BIRTH Month _____Day _____ Year_____

ADDRESS _____

_____

CITY _____**STATE**_____ **ZIP**_____

PHONE (_____)_____ **EMAIL ADDRESS** (Optional):_____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Mission Regional Medical Center
900 S. Bryan Road
Mission TX 78572
956.323.1903 Phone 956-323-1902 Fax

OPTIONS OF ELECTRONIC FORMAT: According to HITECH Section 13405 (e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in. Please note the receiving entity may not accept records in electronic format.

Please select the format you would prefer: ☐Burn to CD ☐Paper ☐Email

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____)_____Fax (_____)_____ Email Address:_____

REASON FOR DISCLOSURE (Choose only one option below)

☐Treatment/Continuing Medical Care ☐Personal Use ☐Billing or Claims ☐Insurance ☐Legal Purposes ☐Disability Determination ☐School ☐Employment ☐Other _____

Covering the Period of Healthcare from _____ to _____

Mission Regional Medical Center

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐**All health information** ☐Emergency Room Record ☐Facesheet ☐History/Physical Exam ☐Past/Present Medications ☐Lab Results ☐Physician's Orders ☐Patient Allergies ☐Operation Reports ☐Consultation Reports ☐Progress Notes ☐Discharge Summary ☐Diagnostic Test Reports ☐EKG/Cardiology Reports ☐Pathology Reports ☐Billing Information ☐Radiology Reports & Images ☐Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results) _____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

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EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month _____ Day _____ Year _____

RIGHT TO REVOKE: I may revoke this authorization at any time, but I must do so in writing and submit to:

Mission Regional Medical Center
ATTN: Medical Records
900 S. Bryan Road
Mission TX 78572

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable):_____

If representative, specify relationship to the individual: ☐Parent of minor ☐Guardian ☐Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam.Code § 32.003).

SIGNATURE X_____
Signature of Minor Individual **DATE**

Definitions - In the form, the terms “treatment,” “healthcare operations,” “psychotherapy notes,” and “protected health information” are as defined in HIPAA (45 CFR 164.501). “Legally authorized representative” as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If “All Health Information” is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding “psychotherapy notes” as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - If requesting a copy of the individual’ s health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual’s physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the “Who Can Receive and Use The Health Information” section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual’s medical care at that entity’s facility or that person’s office, and health care providers who are covering or on call for the specified per son or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization’s staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records.(Tex. Health & Safety Code § 241.154).

Right to Receive Copy – The individual and/or the individual’s legally authorized representative has a right to receive a copy of this authorization.