AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION FORM

PLEASE, FILL OUT ENTIRE FORM TO BE VALID UNDER HIPAA LAWS.

Patient Name:_____Date of Birth:_____MR#_____
Address:_____Phone #:_____SS#_____
City:_____State:_____Zip Code:_____

To be completed by requester: ☐Pick up ☐Mail ☐Other:
If requested health information is needed for a doctor's appointment please specify date:
RECORDS CAN ONLY BE FAXED TO ANOTHER HEALTHCARE PROVIDER.

The following individual or organization is authorized to make the following disclosure:
Name: Texas Health Huguley Hospital Fort Worth South Address: 11801 South Freeway
City: Fort Worth State: TX Zip Code: 76115

Admission/Discharge Date:
Forward to Health Information Management (Medical Records) for:
☐ Abstract ☐ Discharge Summary ☐ Operative Report ☐ Emergency Room Report
☐ Pathology ☐ History & Physical ☐ Laboratory Report ☐ Radiology Report
☐ Consultation ☐ Other (specify) _____
Forward to Patient Business Office for: ☐ Billing Information **Forward to Cardiology Dept for:** ☐ Cath Lab Films
Forward to Radiology Dept for: ☐ X-ray films (specify)
***Abstract consists of facesheet, history & physical, discharge summary, consults, operative notes, emergency record, lab, radiology, physical therapy and rehab (if available).**

Reason for requesting information:_____
Request may be subject to copying fee.

This information may be disclosed to and used by the following individual or organization:
Name:_____
Address:_____
City:_____State:_____Zip:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless, otherwise revoked, this authorization will expire on the following date event or condition (not to exceed 180 days):_____. If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.

Patient Signature:_____Date:_____
Authorized Representative/Parent:_____Date:_____
Printed Name of Authorized Representative/Parent:_____
Relationship to Patient:_____
Address and Phone # of Authorized Representative/Parent:_____

Return this completed form along with a copy of photo ID to the USPS address or fax below
Mail to: Attention: Health Information Management
Texas Health Huguley Fort Worth South
PO Box 6337
Fort Worth, TX 76115
Send FAX to 817-551-2447 DIRECT PHONE 817-551-2741