

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: Pine Creek Medical Center
9032 Harry Hines Blvd.
Dallas, TX 75235
214-572-7137 Fax: 214-572-7138

To Release To: _____ Recipient Name
_____ Street Address
_____ City, State, Zip
Telephone # _____ Fax# _____

The following information from the medical record of:

Patient Name _____ Date of Birth _____
Dates of Treatment: _____ Social Security No.: _____

Information to be released:

Discharge Summary History & Physical Operative Report Path Reports
 Laboratory Reports Consultation Report Medication Report EKG/ECHO
 Progress Notes X-ray Reports Blood Type
 Other _____

The information specified above is to be released for the following purposes:

Treatment/Consultation Patient Request Billing or Claims Attorney
 Social Security Disability Other (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, 1-lepatitis B or C testing, and/or other sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

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 the above address. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that time or unless otherwise specified as follows

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. 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

I understand that Pine Creek Medical Center may not condition my treatment whether I sign this authorization form. I authorize Pine Creek Medical Center to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

Signature of Patient/Legal Representative: _____ Date: _____

Authority to sign if not Patient (documentation required): _____

Identity of Requestor verified by: Photo ID Matching Signature Verified by: _____ Initials