

Authorization for the Use and Disclosure of Protected Health Information



To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996 and state law, Baylor College of Medicine is requesting your authorization for use or release of health information.

This Authorization form gives Baylor College of Medicine your permission to acquire, use or release specified health information for treatment, payment, and health care operations and other purposes: for example, for newspaper or television coverage or for research.

Please complete with Black or Blue Ink or Type

Patient Last Name	First Name	M.I.
Patient I.D. Number		

I hereby authorize disclosure of my health information under the following conditions and limitations:

1. Information may be disclosed to:	Name: Address: Phone: _____ Fax: _____																							
2. Information may be disclosed by:	Name/Entity: Address:																							
3. Information to be disclosed. Check the appropriate boxes in 3(A) to authorize release of the complete medical record or itemized records. (Insert additional details here)	3(A). State type(s) of information that may be disclosed. ___ My complete medical record(s), except for 3.1(B), or:																							
	<table border="1"> <tr> <td>___ Discharge Summary</td> <td>___ Imaging/Radiology</td> <td>___ Billing records</td> </tr> <tr> <td>___ Emergency Room</td> <td>___ Nursing Notes</td> <td>___ Photographs</td> </tr> <tr> <td>___ History & Physical</td> <td>___ Medication Records</td> <td>___ Other</td> </tr> <tr> <td>___ Consultation Reports</td> <td>___ Psychological Records</td> <td>(please specify)</td> </tr> <tr> <td>___ Operative Reports</td> <td>___ Psychiatric Records</td> <td></td> </tr> <tr> <td>___ Rehab Services</td> <td>___ Progress Notes</td> <td></td> </tr> <tr> <td>Type: _____</td> <td>___ Physicians Orders</td> <td></td> </tr> <tr> <td>___ Laboratory Results</td> <td>___ Physician Progress Notes</td> <td></td> </tr> </table>	___ Discharge Summary	___ Imaging/Radiology	___ Billing records	___ Emergency Room	___ Nursing Notes	___ Photographs	___ History & Physical	___ Medication Records	___ Other	___ Consultation Reports	___ Psychological Records	(please specify)	___ Operative Reports	___ Psychiatric Records		___ Rehab Services	___ Progress Notes		Type: _____	___ Physicians Orders		___ Laboratory Results	___ Physician Progress Notes
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3.1. Initial and check box 3.1(B) to indicate whether you consent to the release of the health records described in box 3.1(B).	3.1(B). ___ (initials) IDO [] or IDO NOT [] consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information: _____ NOTE: If this section is not completed, then records of this type if they exist for this patient will not be released.																							
4. Purpose for disclosure:	State specific purpose for disclosure; e.g., "personal use"																							
5. Expiration date of authorization:	State date on which authorization expires. If date is not provided, BCM will accept this signed form for seven (7) years from date of signature. Research expiration date can be "none." ___/___/___																							

6. Authorization granted by: Signature: _____ Print Name: _____
Date: ___/___/___ Relationship to patient: Self Other: _____

Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of the patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan).

7. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.
Signature: _____ Print Name: _____ Date: ___/___/___

You are not required to sign this form as a part of treatment or payment.
*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***
Patient or other party signing this Authorization Form has a right to receive a copy of the Authorization Form. The Authorization may be changed or revoked, in writing, to prevent disclosure of information, except for any previous use of protected health information made in good faith under this Authorization. Baylor College of Medicine, its faculty, staff, residents, and students are hereby released from any legal responsibility or liability for disclosure of the above information covered under this Authorization.