AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

BCM
Baylor College of Medicine

I, _____ (print name) authorize the following health care provider and/or organization to disclose and/or use the following protected health information to the designated person and/or organization for the purposes(s) listed below.

Information disclosed by:	**Information received by:**
_____ (name of health care provider/organization)	Baylor Comprehensive Epilepsy Center (name of person or organization)
_____ (address)	Baylor College of Medicine Department of Neurology 6550 Fannin, Suite 1801, Houston, Texas 77030 (address)
_____ _____ (facsimile number) (phone number)	713-798-7533 713-798-8259 (facsimile number) (phone number)
Disclose the following information: ☐ medical record ☐ billing record ☐ Other: (please specify) _____ ☐ **To be mailed** ☐ **To be picked up by** _____ ☐ **To be sent by facsimile**	**The information is disclosed for the following use(s):**

I do ☐ do not ☐ consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.

I do ☐ do not ☐ consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV(AIDS).

I do ☐ do not ☐ consent to the disclosure of substance/alcohol abuse evaluation/treatment.

This authorization shall expire: _____
(expiration date or event)

I understand the following:

1. I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the health care provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or my eligibility for benefits will not be affected if I do not sign this Authorization.
3. Any information disclosed by this authorization to any person/organization not a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and not longer protected by those regulations.
4. I am entitled to receive a copy of this signed authorization.

_____ _____ _____
(signature of the authorizing individual) (date of birth) (date signed)

_____ _____
(address) (contact phone number/s)

_____ _____
(signature of personal representative with description of authority to act on behalf of the patient) (date signed)

Print Form