AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Baylor College of Medicine

Patient Name: _____ Date of Birth: _____
PLEASE PRINT

I, the undersigned, authorize: _____
NAME AND ADDRESS

to release or give access to the protected health information of the above-named patient to:

_____
NAME AND ADDRESS (STREET, STATE, ZIP) OF INDIVIDUAL OR ENTITY RECEIVING/ACCESSING RECORDS

Phone: _____ Fax: _____

1. METHOD OF DELIVERY
☐ Mail ☐ Fax ☐ Pick-up

2. FORMAT
☐ Paper ☐ Electronic ☐ Other: _____

3. EFFECTIVE TIME PERIOD
This authorization is valid until the earlier of the patient's death, the patient reaching the age of majority, or permission is withdrawn; or the following specific date or event occurs (optional): _____

4. PATIENT INFORMATION IS NEEDED FOR: (Please select at least one option)
☐ Treatment ☐ Disability ☐ Billing/Claims ☐ Legal ☐ Other: _____

5. INFORMATION TO BE RELEASED OR ACCESSED: ☐ All health records from _____ (DATE) to _____ (DATE)

☐ Immunization ☐ Billing ☐ Diagnostic Reports ☐ Other: _____

Your initials are required to release the following information. (Initial in box)

☐ Mental Health (excluding psychotherapy notes)
☐ Genetic Information (including test results)
☐ Drug, Alcohol, or Substance Abuse Records
☐ HIV/AIDS Test results/Treatment

SIGNATURE AUTHORIZATION: By signing below, I understand the following:

a. I may revoke this authorization at any time by sending a written revocation to the person/organization listed above. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.
b. 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.
c. Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
d. I am entitled to receive a copy of this signed authorization.

SIGNATURE X _____ _____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE — DATE

_____
PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

Specify relationship to the patient: ☐ Self ☐ Parent of minor* ☐ Guardian/Ward† ☐ Other†: _____

†Attach documents demonstrating your authority to act on behalf of the patient.

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*A minor's signature is required for release of certain health information, such as information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol or substance abuse and mental health treatment (Tex. Fam. Code §32.003)

SIGNATURE X _____
SIGNATURE OF MINOR — DATE

(Photo identification will be requested to verify the identity of the person signing this authorization.)

Thank you for choosing Baylor College of Medicine for your healthcare needs.
For Questions Contact: roi@bcm.edu ▪ 713.798.5259