AUTHORIZATION FOR USE, REQUEST AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HARRISHEALTH

Patient Information:

Patient First Name: _____ Address: _____
Patient Last Name: _____ City / State / Zip: _____
Medical Record Number or _____
Social Security number: _____
Date of Birth: _____ Phone Number: _____

Phone: 346-426-0980
Fax: 346 426-0959
Email: Releaseofinformation@harrishealth.org

I hereby authorize Harris Health System to release and provide copies of the information indicated below to:

Name: _____ City/State: _____
Phone Number: _____ Zip: _____
Address: _____

☐ **Check this box if the recipient of the requested health care information is your attorney or your legally authorized representative.**

Information To Be Released – Covering the Periods of Health Care:
From (date):_____ To (date): _____

Facility:
☐ All Harris Health Facilities ☐ Ben Taub Hospital ☐ Lyndon B. Johnson Hospital
☐ Clinic(s):

Please check type of information to be released:
Complete Medical Record **[OR the records marked below]**

☐ Billing Record
☐ Clinic Visit(s)
☐ Consultation Report(s)
☐ Discharge Summary
☐ Eligibility Record(s)
☐ Emergency Room Record(s)
☐ Entire Inpatient Record
☐ Entire Outpatient Record
☐ History & Physical
☐ Lab Report(s)
☐ Operative/Procedure Report(s)
☐ Pathology Report(s)
☐ Pathology Slides/Blocks
☐ Radiology Image(s)
☐ Radiology Report(s)
☐ Other: _____
_____
☐ Psychotherapy Notes **(No other boxes maybe checked, if this box is checked)**

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:
I understand and agree that the information requested may contain reference(s) to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information.

Format:
☐ Paper ☐ Compact Disc (CD) ☐ Email: _____ ☐ Other: _____
Email Address (Patients Only)

Purpose of Request/Disclosure (this section is only required if the individual providing this authorization form to Harris Health is someone other than the patient or patient's legally authorized representative)**:**
☐ Treatment or Consultation ☐ Legal ☐ Government Benefit ☐ Request of Patient ☐ Billing/Insurance/Claims ☐ Other: _____

Expiration of Authorization (this section is only required if the individual providing this authorization form to Harris Health is someone other than the patient or patient's legally authorized representative)**:**
This authorization will automatically expire in 180 days from the date of the signature unless: (1) an expiration event or date is provided below; or (2) "none" has been entered when this authorization is for the purpose of research only.

This authorization expires on _____ (Expiration date or event, e.g., discharge from hospital or delivery of requested information).

Withdrawal/Cancellation of Authorization: I understand that this authorization may be withdrawn or cancelled by me or my personal representative at any time by sending written notice to Harris Health System. To withdraw or cancel this authorization, written notice must be sent to: Harris Health System, HIM Release of Information, 4800 Fournace Place, Bellaire, Texas 77401, or via email at AuthorizationWithdrawal@harrishealth.org. The withdrawal or cancellation of this authorization will not change any of the releases of information made before Harris Health is able to make your withdrawal or cancellation of your authorization effective. Please see Harris Health System's Notice of Privacy Practices for more information.

Potential Re-Disclosure:
I understand that once my information is disclosed, it may be re-disclosed by the recipient and no longer protected by state and federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule).

I understand that I do not have to sign this authorization and that my treatment, payment, or enrollment / eligibility for benefits at Harris Health System will not be denied if I do not sign this authorization.

_____ _____
Signature of Patient (or Patient's Personal Representative) Date

_____ _____
Name of Patient (or Personal Representative) (Print) Witness Signature

_____
Personal Representative's Relationship to Patient

TO BE COMPLETED BY HARRIS HEALTH SYSTEM:

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify _____