

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT hereby acknowledges that films, images, interpretation reports, medical records, lab reports, and itemized billing statements (collectively "Medical Records") arising from PROVIDER'S services may constitute Protected Health Information for purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code §181.001 must obtain a signed authorization from PATIENT or PATIENT's legally authorized representative to electronically disclose PATIENT's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. PATIENT hereby authorizes PATIENT'S attorney, PROVIDER and/or PROVIDER'S assigns and business associates to release said Medical Records and all protected health information to persons or entities necessary to diagnose and treat PATIENT'S injuries, as well as persons or entities necessary to review, underwrite, litigate, process, collect or protect PROVIDER 'S and/or PROVIDER'S assign's or business associate's interest or otherwise pursue PATIENT'S claim. PATIENT acknowledges that pursuit of their claim may require PATIENT'S attorney, PROVIDER, and/or PROVIDER'S assigns or business associates, to disclose the Medical Records to third parties who are not subject to the HIPAA privacy standard. PATIENT nevertheless authorizes PATIENT'S attorney, PROVIDER, and/or PROVIDER'S assigns and business associates to release the Medical Records and all protected health information as necessary to pursue PATIENT'S claim and/or to protect PROVIDER and/or its assign's and business associate's interest in PROVIDER'S outstanding balance. This authorization is valid until the earlier of the occurrence of PATIENT'S death, PATIENT reaching the age of majority, or permission is withdrawn. Additionally, PATIENT'S attorneys' authority under this authorization shall expire upon dismissal, abandonment, settlement, satisfaction, or judgment of PATIENT'S claim or upon termination of PATIENT'S attorneys' representation of PATIENT. PROVIDER'S and/or its assign's and business associate's authority under this authorization shall expire upon full satisfaction of the outstanding balance owed to PROVIDER and/or PROVIDER'S assigns. In the interim, PATIENT shall have the right to revoke this authorization at any time. PATIENT understands that prior actions taken in reliance on this authorization by persons or entities that had permission to access PATIENT'S health information will not be affected. By signing below, PATIENT is representing that PATIENT has read the above and agrees to the uses and disclosures of the information as described. PATIENT understands that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without PATIENT'S specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code §181.154(c) and/or 45 C.F.R.

§164.506(a)(1). PATIENT understands that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

\_\_\_\_\_  
PATIENT or PATIENT's legal representative

Print: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship: ☐ Parent ☐ Guardian ☐ Other: \_\_\_\_\_

If PATIENT is a minor: A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g. Tex. Fam. Code §32.003).

\_\_\_\_\_  
Signature of Minor Patient

\_\_\_\_\_  
Provider's Initials: \_\_\_\_\_

Patient's Initials: \_\_\_\_\_