

MARTIN COUNTY HOSPITAL DISTRICT

600 Interstate 20 East / Stanton, Texas 79782

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, 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.

I authorize Martin County Hospital District to ☐ disclose ☐ obtain the following named individual's protected health information:

Last,	First	Middle
()		
Date of Birth	Phone	
Complete Address		
Email Address		

Name, Address, Email or Fax of Person/Entity to whom information will be sent:

Delivery Method: Fax ☐
Email ☐ Mail ☐ Pick up ☐

Relationship to person receiving information:

I authorize the disclosure of the following protected health information: Clinic Record ☐ Hospital Record ☐ 9Y\$13\$y0ë w22Y ☐

Date(s) of Service: _____

☐ History & Physical ☐ Discharge Summary ☐ Operative Report ☐ Laboratory ☐ Radiology
☐ Billing Information ☐ Most Recent 1 yr History ☐ Complete Record ☐ Other: _____

Your initials are required to release the following information:

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

REASON FOR DISCLOSURE:

☐ Treatment/Continuing Medical Care ☐ Personal Use ☐ Billing/Claims ☐ Insurance ☐ Legal
☐ Disability Determination ☐ Employment/School ☐ Other: _____

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that I may refer to the Martin County Hospital District Notice of Privacy Practices for information about how my protected health information is used and disclosed. I understand that when receiver obtains my protected health information via electronic format, Martin County Hospital District is no longer responsible for further disclosure and any breach of my information.

RIGHT TO REVOKE: I understand that I can revoke my authorization at any time by giving written notice to Martin County Hospital District. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon the following specific date (optional): _____.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand 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 my specific authorization or permission including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).

Signature of Individual or Individual's Legally Authorized Representative

DATE

Printed Name of Legally Authorized Representative (if applicable)

Relationship to Patient

For HIM Department Use email to: medrec@martinch.org

DL Attached ☐

Scanned into Chart: ☐

Release Processed by: