



Locations

- Museum District Medical Center
 W. Houston Katy Pearland Pasadena

www.diagnosticclinic.com

Authorization To Disclose Protected Health Information

Date _____

Date of Birth _____

Patient Name (Last) _____ (First) _____ (MI) _____ Sex _____

In general, the HIPAA privacy rule gives individuals the right to request uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or discussing PHI with family members.

This Standard Authorization gives the doctors and staff of Diagnostic Clinic of Houston your permission to speak to or give written documentation about your medical health information to the person/persons you have designated.

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Name _____ Restrictions _____
 Relationship _____ Phone # _____

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 Relationship _____ Phone # _____

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 Relationship _____ Phone # _____

WHAT INFORMATION CAN BE DISCLOSED?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other |

Your initials are required to release the following information:

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

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ___ Day ___ Year _.

RIGHT TO REVOKE. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." 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.

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 other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand 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.

Signature of Patient or Guardian

Date