SOUTHWEST CHILDREN'S CENTER

Southwest Children's Center, P.A.
5282 Medical Drive, Suite 310
San Antonio, Texas 78229
Telephone: (210) 614 TOTS (8687)
Fax: (210) 614-PLAY (7529)

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 (Tex. Health & Safety Code §§181.154(b)(c), §241.153; 45 C.F.R. §§164.502(a)(1); 164.506, and 164.508).Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

_____
NAME OF PATIENT *(please print)*

_____
OTHER NAME(S) USED

_____/_____/_____ _____
DATE OF BIRTH PHONE NUMBER

_____
STREET ADDRESS

_____
CITY STATE ZIP

I HEREBY AUTHORIZE: *(please print)*

Name: _____

Phone: _____

Fax: _____

TO RELEASE RECORDS TO: *(please print)*

Name: _____

Phone: _____

Fax: _____

WHAT INFORMATION CAN BE DISCLOSED?

□ All Health Information *(fee may apply)*
□ Immunization Record □ Lab Results
□ Vision & Hearing □ History & Physical
□ Radiology Reports □ Office Notes
□ Specialist Reports □ Billing Information
□ Other *(please specify)*: _____
Covering the period from _____ to _____

REASON FOR DISCLOSURE :

(choose only one option below)
□ Transferring Care to New Primary Care Physician
□ Personal Use □ Continuing Medical Care
□ School □ Employment
□ Legal Purposes □ Billing/Insurance
□ Disability Determination
□ Other *(please specify)*: _____

_____ (*Initial*) I understand, unless otherwise stated, this authorization will include information relating to:
● Psychiatric Care ● Treatment for alcohol and/or drug abuse ● HIV/AIDS Testing Results/Treatment ● Genetic Testing

The date, extent, or condition upon which this authorization expires is _____ not to exceed 24 months (except for research purposes, state **"NONE"** for expiration date). 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 "RELEASE RECORDS TO." I understand that prior to actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer if needed. (Texas Health & Safety Code §241.154) I may inspect or copy any information to be used or disclosed under this authorization. I further understand that **Southwest Children's Center, P.A.**'s records may contain information created by an entity other than **Southwest Children's Center, P.A.** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility, or lack thereof of such incorporated records).

PLEASE SIGN AND DATE ON THE BACK OF THIS FORM

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I hereby release **Southwest Children's Center, P.A.** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Southwest Children's Center, P.A.** is not responsible for completeness, legibility, or omissions caused by the copying of any medical records from another institution.

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 disclosers to covered entities as provided by Texas Health & Safety Code §181.154(c) and/or 45 C.F.R. §164.502(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 Patient's Representative _____ Date _____

Printed Name of Patient or Patient's Representative _____ Relationship to Patient _____

ADDITIONAL INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Developed for Texas Health & Safety Code §181.154(d) effective June 2013

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code §151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code §3(aa)).

Health Information to be Released – If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information.

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§164.502(a)(1)(i), 164.524; Tex. Health & Safety Code §181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental, or emotional health. (Tex. Health & Safety Code §§181.102, 611.0045(b); Tex. Occ. Code §159.006(a); 45 C.F.R. §164.502(a)(1)). If a healthcare provider is specified in the "RELEASE RECORDS TO" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses or medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. §164.522(a)(1)(vi)).

Limitations of this form – This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. §164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. §164.508(b)(3)(ii); or for research purposes (45 C.F.R. §164.508(b)(3)(i)). Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of this form.