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**Authorization for Release and/or Disclosure of Health Information**

I authorize the disclosure of my personal health information to the persons/entities as described below. I understand this authorization is voluntary, and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission to El Buen Samaritano to disclose my personal health information in the manner described herein.

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| **PATIENT’S INFORMATION** |
| Name: | Medical Record #: |
| Birthdate: | Contact Phone Number: | Request Date: |
| **PHI MAY BE DISCLOSED BY:** |
| Person/Facility: El Buen Samaritano Episcopal Mission | Phone: (512) 439 - 0700Fax #: |
| Address: 7000 Woodhue Drive, Austin, TX 78745 |
| **PHI MAY BE DISCLOSED TO** |
| Person/Facility: | Phone #: Fax: #: |
| Address: |

**PERSONAL HEALTH INFORMATION TO BE DISCLOSED:** Specify records to be released and/or disclosed.

□ General medical information (from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Information regarding specific injury or treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (from\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_)

□ X-ray/laboratory results of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (from\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_)

□ Mental Health (from \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Initials of Patient or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Alcohol/Drug (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Initials of Patient or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_

□ HIV/AIDS/STI test results (from \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_) Initials of Patient or Representative \_\_\_\_\_\_\_\_

□ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your request will be deemed to include any information related to sexually transmitted disease, alcohol or drug use or treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Right to Revoke:*** *I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before El Buen Samaritano received and processed a written notice of revocation. I understand that if I did not specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below. To revoke this authorization, I understand that I must send a written request to El Buen Samaritano, ATTN: Privacy Officer, 7000 Woodhue Drive, Austin, TX 78745.*

**ACKNOWLEDGEMENT**

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to El Buen Samaritano to release nonpublic personal health information. I understand that El Buen Samaritano will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

By: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature Patient’s Printed Name Date

***If you are not the patient, please complete, sign and date below, indicating your relationship to the patient. Please attach proof or your relationship to the participant.***

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ Representative’s Signature Representative’s Printed Name Date

**□ Parent of Minor Child □ Legal Guardian □ Power of Attorney □ Executor**