

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION AND PATIENT ACCESS

I.	PATIENT INFORMATION
	Patient Name:
	Date of Birth: Social Security Number:
	Patient's Mailing Address:
	Telephone number: Work Home Cell
II.	INFORMATION TO BE USED OR DISCLOSED
	For Date(s) of Service:
	□ Outpatient Clinic Record □ Billing Record
	□ Films □ Pictures □ Other
ш.	I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. INFORMATION TO BE USED BY OR DISCLOSED TO:
	Name of Recipient (Family Member) :
	Telephone Number: Fax Number:
IV.	PURPOSE OF USE OR DISCLOSURE:
V.	 I authorize the use or disclosure of health information as described above. I understand: This authorization is valid for 180 days unless otherwise stated here: A photocopy or fax of this authorization is as valid as the original. I may revoke this authorization at any time by submitting a revocation in writing to [Methodist Urology Associates]. If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received. Treatment or payment may not be conditioned on my completion of this authorization form. If the Recipient identified above is not covered by Federal or Texas privacy laws, the information may not be protected under these laws once it is disclosed to the Recipient and, may be subject to re-disclosure by the Recipient. I may be asked to provide proof of my identity/guardianship with this authorization. Fees/charges will comply with all laws and regulations applicable to release of protected health information. Payment is due at time of release of information.
	Signature of Patient or Qualified Personal Representative * Date * If signed by a Qualified Personal Representative, the following must be completed:
	Printed name of Qualified Personal Representative:
	Legal Documentation showing Authority to Act on Behalf of the Patient:(Example: Guardian of Patient, Executor of Estate)
	For Internal Use Only
V	rification of Signature/Authority: Date: