**Authorization for Release of Personal Health Information (PHI)**

**Must BE Completed for All Authorizations:**

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affects treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Person/organization providing the information:** | **Person/organization receiving the information:** |
|  | Boerne Healthcare Group |
|  | 17 Old San Antonio Road, Suite 202 |
|  | Boerne, Texas, 78006 |
|  | Fax: 210-519-3012 |

**The purpose for this authorized release of information is** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is at the request of the individual.

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked they cannot be released.

|  |  |  |  |
| --- | --- | --- | --- |
|  Drug Abuse |  Substance Abuse |  Psychological or Psychiatric conditions |  AIDS/HIV |

**Please release the following records:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | History & Physical |  | Recent lab results |  | Recent Imaging Results |  | Progress Notes |
|  | All records generated in your office |
|  | Records that apply to these specific dates of treatment |
|  | Records that apply to this specific problem or intervention |

Are you leaving our practice? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Must be Completed for All Authorizations:**

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations ad that the information may be redisclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Patient’s Representative Date Printed Name of Patient or Patient’s Representative**

**­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Revocation of Authorization:**

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the practice. I further understand that any such revocation oes not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby revoke this authorization, effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Patient’s Representative Date Printed Name of Patient or Patient’s Representative**