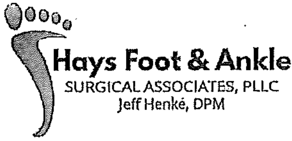

135 Bunton Creek Rd., Ste. 300
Kyle, TX 78640
Ph 512-268-3668 Fax 512-268-5785

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand Hays Foot and Ankle Surgical Associates, PLLC is authorized by me to use or disclose my protected health information ("PHI") for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

I specifically authorize Hays Foot and Ankle Surgical Associates, PLLC or its designated employee(s) to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization if I do so in accordance with the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

☐ My entire record

Note: This requires an explanation of why it is necessary to disclose the entire record.

____

____

____.

☐ My demographic information *(check all that apply)*:

□ Name □ Address □ State/Zip Code only □ Telephone
□ Age □ Gender □ Race □ Other ____________________

☐ Medical Data/Information related to:

□ Specific condition(s)______________
□ Specific professional service(s)____
□ Specific medication(s)____
□ Other ____

☐ Other ______________________________

Please disclose the above information to:

Name ____ Phone Number ______________

Address ____

I do / do not (please circle) authorize this information to be faxed. If yes, fax number ________________

Name(s) or class of person(s) to whom Hays Foot and Ankle Surgical Associates, PLLC may disclose my PHI to:

____

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Purpose(s) for the disclosure of the information: ____
____
____.

Note: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure."

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. For the revocation of this authorization to be effective, Hays Foot and Ankle Surgical Associates, PLLC must receive the revocation in writing and the revocation must include:

- My name and address
- The effective date of this authorization and the recipients of the PHI according to this authorization
- My desire to revoke this authorization
- The date of the revocation, and
- My signature.

Hays Foot and Ankle Surgical Associates, PLLC will accept written revocations of this authorization via:

☐ Certified U.S. mail

☐ Facsimile at this number: 512-268-5785

All revocations must be sent to Hays Foot and Ankle Surgical Associates, PLLC and are not effective until received by them.

This authorization shall expire on ____________________. After this date, Hays Foot and Ankle Surgical Associates, PLLC can no longer use or disclose my PHI for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient Name ____________________________________

Patient Signature ____________________________________ Date ______________

Name of Representative______________________________

Relationship to Patient ______________________________

FOR OFFICE USE, ONLY

☐ Authorization added to the patient's record on ______________________________.

☐ Authorization verified by ____________________________________ on__________________________.

☐ Patient has been provided with a copy of the signed authorization.