

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Austin Lakes Hospital 1025 E. 32nd Street, Austin, Texas 78705

Phone: 512-544-8496 Fax: 512-544-8958

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

I hereby freely and voluntarily authorize Austin Lakes Hospital to (check box below):

Release/disclose my protected health information to: **OR** **Obtain my protected health information from:**

NAME: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

This information is necessary for: Follow-up Care Patient Request / Personal** Attorney / Legal** Disability Benefits**

Other** (explain): _____ ****Indicates Fee for Service (Cost based on page count)**

Please disclose the following: Physician Progress Note(s) History & Physical Psychiatric Evaluation Psycho Social

Discharge Summary Treatment Plan Medication List Lab Results Face sheet Leave of Absence Request

Other (explain) _____

I give special permission to release any information regarding items listed below:

Alcohol, Drug, or Substance abuse Records **YES** **NO** **INITIAL:** _____

HIV / AIDS Medical Information **YES** **NO** **INITIAL:** _____

Psychotherapy Notes **YES** **NO** **INITIAL:** _____

Please disclose my information via: **FAX** **MAIL** **PICK-UP** **VERBAL**

By signing this authorization, I understand that:

- Requests for copies of medical records are subject to **Fee for Service** in accordance with federal/state regulations.
- I have the right to **REVOKE** this authorization at any time. I can revoke this authorization during my stay, please specify below.
- After I discharge, revocation must be made in writing and presented to the Health Information Management Department at the following address: 1025 E. 32nd Street, Austin, TX 78705. Revocation will not apply to information that has already been disclosed in response to this authorization.
- This authorization will expire one year from the date signed unless otherwise specified (Otherwise specified date _____).
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure.
- Copy of driver's license or identification card must accompany all requests.

*******THIS AUTHORIZATION FORM IS ONLY VALID WHEN FULLY COMPLETED*******

Patient Signature or Authorized Representative (Guardian)

DATE

TIME

Relationship to Patient

Witness

DATE

TIME

Relationship to Patient

This Authorization has been revoked effective:

Patient Signature or Authorized Representative (Guardian)

DATE

TIME

Relationship to Patient

Witness

DATE

TIME

Relationship to Patient