Southwest Surgical Associates, L.L.P.

Authorization to Disclose Protected Health Information

Name of Patient or Individual

First Middle Last

Other Name(s) Used _____

Date of Birth Month _____ Day _____ Year _____

Address _____

_____

City _____ State _____ Zip _____

Phone (____) _____ Alt Phone (____) _____

Email Address (optional) _____

Reason for Disclosure:

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purpose
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

I authorize the following to disclose the individual's protected Health Information (Provider/Facility to release information):

Provider/Facility Name: _____

_____

Phone: (_____) _____

Fax: (_____) _____

Who can receive and use the Health Information?

Person/Provider/Facility Name: _____

_____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____

Fax: _____

What information can be disclosed? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box.

☐ All Health Information ☐ History & Physical ☐ Operative Reports ☐ Lab Results ☐ Progress Notes ☐ Discharge Summary

☐ Pathology Reports ☐ Billing Records ☐ Diagnostic Test Reports ☐ Other: _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)

_____ Genetic Information (including Genetic Test Results)

_____ Drug, Alcohol or Substance Abuse Records

_____ HIV / AIDS Tests Results / Treatments

Effective Time Period: This authorization is **valid for one year** from the date it is signed; the individual reaching the age of majority; or permission is withdrawn; **or the following specific date (optional)**: Month _____ Day _____ Year _____

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Who can receive and use the Health Information." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154 (c) or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

This authorization is given freely with the understanding that any and all records, whether written or oral or in electric format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law; a photocopy or fax of this authorization is as valid as the original. Southwest Surgical Associates L.L.P., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Treatment, payment, enrollment or eligibility for benefits may be conditioned upon obtaining the authorization.

Signature X _____ _____

Signature of Individual or Individual's Legally Authorized Representative — Date

Printed name of legally authorized representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other _____