Orthopedic & sports medicine Institute of New Braunfels

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____
Date of Birth_____ Social Security # _____
I hereby authorize the following Physician or Hospital to disclose the above named individual's health information:

_____Address_____

For the purpose of:_____

Please release the following:

_____Admission Face Sheet	_____Consultation	_____Physician Orders
_____Discharge Summary	_____Op. Report	_____Nurse Notes
_____H & P	_____Lab Record	_____Outpt Record
_____Progress Notes	_____Image Record	_____ER Record
_____PT/RT/OT Record	_____ Med Record	_____Office Record

_____Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
___**Yes,** I consent to the release of this information. ___**No,** I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the physician or hospital releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or
condition:_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.534. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact, Ellen M. Cochran, Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship of Patient (if Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding for the information contained in these entries. I will not hold David B. Templin, M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

Date request completed_____# paged copied _____Reviewed only____
Charge $_____Cash_____Check #_____Initials_____

This information has been released to you from records where confidentiality is protected by Federal Law. Federal Regulations (42CFR, Part 2) prohibits you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.