AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

*This authorization may be used to permit a covered entity (as defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete **all** the sections that apply to their decision relating to the use or disclosure of their protected health information.*

Information regarding patient for whom authorization is made:

Full name of patient:_____

Other names used:_____ Date of Birth: _____

Address:_____ City: State: Zipcode:

Phone:_____ Email:_____

Healthcare Provider or entity "AUTHORIZED TO DISCLOSE" this information:

Name:_____

Address:_____ City: State: Zipcode:

Phone:_____

Healthcare Provider or entity who "CAN RECEIVE" and use this information:

Name: Dorothy J. Roach, M.D. / North Houston Center for Reproductive Medicine

Address: 111 Vision Park Blvd. #110, The Woodlands State: TX Zipcode: 77384

Email ONLY to: staff@nhcrm.com – NO FAXES PLEASE

Specific information to be disclosed – we are only interested in these specific records:

Laboratory, imaging and surgical reports

Include: (Indicate by Initialing)

_____HIV/AIDS – Related Information (including HIV/AIDS test results)

Reason for release of information: (choose all that apply)

_____Treatment/Continuing Medical Care
_____Insurance
_____ Legal Purposes
_____Personal Use
_____Disability Determination
_____Other (Specify):_____

The individual signing this form agrees and acknowledges as follow:

(i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be condition upon my signing of this authorization form.

(ii) Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month: _____ Year: _____

(iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) If information is being released to me, I understand that my medical record 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 of the information that has been written in the record. I will not hold North Houston Center for Reproductive Medicine or Dorothy J. Roach, M. D. liable for any misinterpretation of the protected health information as a result of not consulting my physician for the correct interpretation.

(vi) Signature Authorization: I have read this form and agree to the uses and disclosure 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. 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.

Signatures:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness: _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain type of reproductive care, sexually transmitted diseases, drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____