



Medical Records Requests are subject to a \$6.50 processing fee

Email your request to: document@swpedi.com

Authorization to Disclose Protected Health Information

Please read this entire form prior to signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is define by HIPAA and Texas Health and Safety Code § 181.001 must obtain a signed authorization form from the individual or the individual’s legally authorized representative to electronically disclose that individual’s protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility of benefits.

Name of Patient or Individual

Last _____ First _____ Middle _____ Date of Birth: _____

I authorize the following to disclose the individual’s protected health information: (Current Holder of Records)

Person/Organization Name: _____

Address: _____

Street City State Zip Code

Phone (____) _____ Fax (____) _____

Who can receive and use the health information?

Person/Organization Name: _____

Address: _____

Street City State Zip Code

Phone (____) _____ Fax (____) _____

Parents/Guardians: How would you like to receive medical records:

CD/Mailed CD/Pick Up in office Email-Encrypted _____@_____

Reason for Disclosure (Choose only one option)

Treatment/Continuing Medical Care Personal Use Billing or Claims Insurance Legal Purposes

Disability Determination School Employment Other _____

What information can be disclosed? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- All Health Information
- History/Physical Exam
- Past/Present Medications
- Lab Results
- Physician’s Order
- Patient Allergies
- Operation Reports
- Consultations
- Progress Notes
- Discharge Summary
- Diagnostic Test Reports
- EKG/Cardio
- Pathology Reports
- Billing Information
- Radiology Reports/Images
- Other _____

Effective Time Period. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following date: ____/____/____

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 and Safety Code § 181.154(c) and/or under §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 and state privacy laws.

Signature of Individual or Individual’s Legally Authorized Representative

Date

Printed Name of Legally Authorized Representative _____

Relationship: Parent of Minor Guardian Other _____