TEXAS ONCOLOGY AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. 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 for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day_____Year _____

PHONE (_____)_____**ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____State_____ZIP_____

Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____Fax (_____)_____

Email: _____

REASON FOR DISCLOSURE (Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing, Claims, or Insurance
- ☐ Health Oversight Activities *(complete page 3)*
- ☐ Legal Purposes *(complete page 3)*
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

METHOD OF RELEASE ☐ **Email** ☐ **US Postal Service** ☐ **Print for pick-up**

WHAT INFORMATION CAN BE DISCLOSED?

Date of Service: _____

- ☐ All Health Information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other

Your initials are required if you wish to release any of the following information:

_____Mental Health Records (excluding psychotherapy notes)

_____Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including Genetic Test Results)

_____HIV/AIDS Test Results/Treatment

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earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____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 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.

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 :

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MORE INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is intended for use in complying with the requirement s of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181).

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information, in certain circumstances. 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. (Tex. Health & Safety Code §§ 181.154(b),(c), §241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that Texas Oncology can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a) (1)).

Prohibited Uses: Federal law prohibits use and disclosure of health information for criminal, civil, or administrative investigations or proceedings for the "mere act of" seeking, obtaining, providing, or facilitating reproductive health care that was legal when it was provided is prohibited. This type of information cannot be shared without first getting an assurance from the third party requesting the health information that the information will not be used for a prohibited purpose.

Examples of reproductive health care include but are not limited to; birth control, pregnancy screening, prenatal care, miscarriage management, pregnancy termination, and other types of care, procedures, services, and supplies used for the diagnosis and treatment of conditions related to the reproductive system.

Texas Oncology will obtain a written and signed attestation from any third party requesting the information for the purposes of Judicial and Administrative Proceedings, Health Oversight Activities, Law Enforcement, Public Health Activities that it will not be used for a prohibited purpose.

Charges - There may charge a retrieval/processing fee and for copies of medical records under certain circumstances. (Tex. Health & Safety Code § 241.154).

Right to Receive a Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

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PROHIBITED USE ATTESTATION

Patient Name: _____

Requester Name: _____

Recipient Name: _____

Select the purpose of the information you are requesting:

☐ health oversight activities ☐ judicial and administrative proceedings

☐ law enforcement purposes ☐ disclosures about decedents to coroners and medical examiners

Description and date range of records being requested:

I attest this information is not intended for a purpose prohibited under 45 CFR 164.502(a)(5)(iii).

☐ a. This information is **not** intended for use in criminal, civil, or administrative investigations or proceedings against persons for "mere act of" seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it is provided. *No further information is required. Proceed to end and sign.*

☐ b. This information is intended for use in criminal, civil, or administrative investigations or proceedings against persons for obtaining reproductive health care that was against the law at the time and in the location, it was provided. Supporting documentation is attached.

Documentation to support the determination that the services in question were illegal at the time and place they were performed is required.

Supporting documentation and the totality of the request for information is subject to review by the covered entity.

Attestation: By signing this form, I do hereby attest that this information is true and accurate to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability pursuant to 42 U.S.C. 1320d-6.

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Institution: _____