AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Name (First, Middle, Last):		Date of Birth:	

1. Please release the requested information to:

TO: Texas A&M Coastal Bend Health Education Center	**FROM:**

2. 1 authorize this information to be disclosed in the following manner:

☐ Written/Photocopy/Paper ☐ Verbal ☐ Fax ☐ Electronically

3. Purpose(s) for the disclosure of the information:

4. Description of information to be used and/or disclosed:

Dates of Treatment:	☐ All Records ☐ From _____ To: _____

Special reports to be disclosed:

☐ Visit Notes ☐ Laboratory Reports ☐ Consultation Reports ☐ Health Summary ☐ Appointment History

☐ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, and other referral documents) Other: _____

I understand Texas A&M Coastal Bend Health Education Center is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or healthcare operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Texas A&M Coastal Bend Health Education Center or his/her designated employee(s) to disclose my Protected Health Information as described on the form the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, the revocation must include:

- My name and address
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization
- My desire to revoke this authorization, and
- The date of the revocation, and my signature.

Texas A&M Coastal Bend Health Education Center will accept written revocations of this authorization via:

☐ Certified U.S. Mail ☐ Facsimile to this number: 361-561-8644

ALL revocations must be sent to Texas A&M Coastal Bend Health Education Privacy Officer and are not effective until received by him/her.

This authorization shall expire on _____. After this date, Texas A&M Coastal Bend Health Education Center can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization.

I fully understand and accept the terms of this authorization.

_____ _____

Signature of Participant or Participant Representative Date

_____

Name of Participant

_____ _____

Name of Representative (if applicable) Relationship to participant

FOR OFFICE USE ONLY

☐ Identification verified by: _____ ☐ DL ☐ Picture ID ☐ Legal Document ☐ Other: _____

☐ Authorization added to the participant's record on _____

☐ Authorization verified by _____ on _____

☐ Participant has been provided with a copy of the signed authorization