COASTAL BEND HEALTH EDUCATION CENTER
TEXAS A&M UNIVERSITY

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ___________________________________ Date of Birth: __________________

1. **Please release the requested information**:

TO: Texas A&M Health Science Center – CBHEC

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FROM: _________________________

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

❒ Written/Photocopy/Paper ❒ Verbal ❒ Fax ❒ Electronically

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

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4. **Description of information to be used 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 Health Science Center Coastal Bend Health Education Center (TAMHSC-CBHEC) is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care 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 TAMHSC-CBHEC or his/her designated employee(s) to disclose my Protected Health Information as described on this form to 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 a 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, TAMHSC-CBHEC must receive the revocation in writing, and 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.

TAMHSC-CBHEC will accept written revocations of this authorization via:

❒ Certified U.S. mail or ❒ Facsimile at this number: ________________________

ALL revocations must be sent to TAMHSC-CBHEC Privacy Officer, and are not effective until received by him/her.

This authorization shall expire on _______________. After this date, TAMHSC-CBHEC can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

____ ______________________

Signature of Patient or Patient's Representative Date

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Name of Patient

____ ______________________

Name of Representative (if applicable) Relationship to patient

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FOR OFFICE USE ONLY

❒ Identification verified by: _________ ❒ DL ❒ SS ❒ Picture ID ❒ Legal Document ❒ Other: _______

❒ Authorization added to the patient's record on ______________________________

❒ Authorization verified by ____________________________________ on ______________

❒ Patient has been provided with a copy of the signed authorization.