Wilson N. Jones Regional Medical Center

Health Information Management Department
Phone: 903-870-4100 500 N. Highland Ave.
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____MR#:_____

Date of Birth: _____ Phone number: _____

Date(s) of Treatment: _____

NAME OF PERSON OR ENTITY INFORMATION IS TO BE RELEASED TO:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____ Fax Number: _____

INFORMATION TO BE RELEASED:

- ☐ Pertinent Package/Abstract
- ☐ Radiology Report/Imaging
- ☐ Laboratory Report
- ☐ Shot Records
- ☐ History & Physical
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ EKG/Echocardiogram
- ☐ ER Records
- ☐ Other: _____

The information is being released for the following purpose:

- ☐ Continued Medical Care
- ☐ Billing or Claims
- ☐ Social Security/Disability
- ☐ Attorney
- ☐ Patient Request
- ☐ Other: _____

Sensitive Information Record Release:

- I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Initial one: Yes _____ No _____**
- I understand that if my medical or billing record contains information in reference to HIV/AIDS testing and/or treatment, I agree to its release. **Initial one: Yes _____ No _____**

Time Limit and Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Facility Privacy Officer at the above address. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that time or unless otherwise specified as follows:

_____

Re-disclosure:
I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing this document, I authorize Texas Health Presbyterian-WNJ to use and disclose the protected health information as specified above. I understand that I need not sign this form in order to ensure healthcare treatment, payment, enrollment in my health plan, or eligibility for benefits. I further understand that a reasonable copy fee may be charged for copies.

_____ _____ _____

Signature of patient or legal representative **Relationship to patient** **Date**

To be completed by facility:

Identity of requestor verified by: _____Photo ID _____ Supporting Documents