AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

This document must be signed by the patient or person authorized by law.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____Social Security Number _____

Other identifying information if applicable (other names): _____

Transmission by facsimile or electronic means authorized to expedite transfer of records.

I, _____ hereby authorize Austin Plastic & Reconstructive Surgery to release the records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.
This Authorization for Release of Protected Health Information applies only to the release of the records identified on Exhibit A. Such records should be released to _____

_____[name and address of recipient] for the following purpose(s): ___

_____

_____.

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from Austin Plastic & Reconstructive Surgery. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.
I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.
This Authorization for Release of Protected Health Information shall expire one (1) year from the date below.
My signature below acknowledges that I have read, understand, and authorize the release of the information described on Exhibit A.

_____ _____

Patient or Person Authorized to Sign for Patient Date/Time

_____

Printed Patient Name

EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION
SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from _____ to _____ [insert dates]:

___ Complete medical record (all information)
___ All hospital/institution records (includes nursing records/progress notes)
___ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
___ Laboratory reports
___ Pathology reports
___ Diagnostic imaging reports
___ EKG/cardiac reports
___ Physical/occupational therapy reports
___ Billing statements
___ Physician office/clinical records
___ Implant information (including operative report)
___ Photographs

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information:

___ HIV/AIDS information
___ Mental health information
___ Genetic testing information
___ Drug/alcohol diagnosis, treatment, or referral information