The Austin Diagnostic Clinic

MRN

Authorization for Release of Protected Health Information (PHI)

Patient Name | Date of Birth

Address | Telephone Number

I hereby authorize (name of facility/provider **releasing** information) **to disclose the above-named individuals health information:**

Name (facility releasing information) | **Address** | **City** | **State** | **Zip**

Telephone Number

Date(s) of Service Requested (if known) or Provider: ____

Description of Information to be released: (check all that apply)

- ☐ Progress notes
- ☐ Consultations
- ☐ Most recent history and physical
- ☐ Immunization record
- ☐ Other____
- ☐ Laboratory reports
- ☐ Radiology/Imaging reports
- ☐ Radiology films
- ☐ Two-way verbal exchange of communication
- ☐ Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Name (facility receiving information) | **Address** | **City** | **State** | **Zip**

Telephone Number

Description of the purpose of the use and/or disclosure: (check one)

- ☐ Continuing Care
- ☐ Consultation
- ☐ Legal purposes
- ☐ Second Opinion
- ☐ Insurance
- ☐ Personal Use
- ☐ Emergency/acute care
- ☐ Social Security/Disability (provide copy of SSA Letter)
- ☐ Other: Please describe: ______________________________
- ☐ Marketing - If this request is for marketing purposes, ADC may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information (PHI).

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. The Austin Diagnostic Clinic may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until ______________________________ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at The Austin Diagnostic Clinic. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_______________________________________ | _______________________________________

Signature of Patient or Patient's Representative | **Date**

____

Printed name of Patient or Patient's Representative

_______________________________________ | _______________________________________

Relationship to Patient **or** **Legal Authority (attach supporting documentation)**