Authorization for Release of Information (To HTPN)

HEALTHTEXAS PROVIDER NETWORK
Affiliated with Baylor Health Care System

I hereby authorize _____ _____
Entity or Person **from** whom records are requested Address

_____ _____ _____ _____ _____
Telephone Fax City State Zip

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. 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 understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ _____ _____
Patient Name (please print) Date of Birth Social Security Number

_____ _____
Patient Address (City, State and Zip) Phone Number

_____
Specific Date(s) of Service (if known) ☐ All Dates of Service

Information to be released: (Check all that apply)

☐ **Complete Medical Records** ☐ Radiology Reports & Films ☐ Registration Records ☐ Billing Records
☐ Visits & Encounters ☐ Laboratory Reports ☐ Consultation Reports ☐ Emergency Room
☐ Laboratory Reports ☐ Operative Records ☐ Other: _____

_____
Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to**:

Category: ☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other_____

_____ _____
Name of Person or Entity (please print) Phone Number

_____ _____
Address (City, State, and Zip) Fax Number

Delivery Method: ☐ Mailing Address ☐ Fax ☐ Pick-Up Records ☐ Other_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that 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, Parent, or Legal Guardian **Date**

_____
Printed Name of Patient, Parent, or Legal Guardian

_____ _____
Relationship to Patient **or** **Legal Authority** (Attach Supporting Documentation)