Regional Digestive Consultants, PA

Universal Authorization for the Use and Disclosure of Protected Health Information

To request medical records from another provider, hospital, or other healthcare facilities.

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1. **I hereby authorize** _____ (**name of physician or healthcare facility**)
_____ (**address: street, city, state, zip**)
_____ (**telephone number, fax number**)
to use and disclose protected health information from the record(s) of:
Patient's Name (Print): _____
Date of Birth (mm/dd/yyyy): _____ or **SS#**: _____

2. Copies of the following records shall be used and disclosed:

_____ Complete Clinical Records; or
_____ Other (Please specify exact information to be disclosed, including dates of service.)
_____ Check here if you do not want your records sent via electronic means (eg. NextMD or on a CD/DVD)

I authorize Regional Digestive Consultants, P.A. to use or disclose (as applicable) the following information (check all that apply):

□ **Provider Notes** □ **Lab Reports** □ **HIV Results/Testing** □ **Radiology Reports**
□ **Operative/Procedure Reports** □ **Pathology Reports** □ **Hospital Records** □ **Research Records**
□ **Infusion Records** □ **Billing Statement** □ **Procedure Images** □ **Special Tests**
□ **Other (Please specify):** _____

Please exclude the following information: □ Drug, Alcohol, Substance Abuse Records □ Mental Health □ HIV/Aids-related Information □ Genetic Information
Please indicate dates of treatment: _____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check one or more as applicable)

_____ Sent to: Name of Recipient: _____
Name of Company: _____
Address: _____
City: _____ State: _____ Zip: _____

_____ Faxed to: Name of Recipient: _____
Name of Company: _____
Fax Number: _____
Confirmation Telephone Number: _____

_____ Made Avail to: Name of Recipient: _____
Confirmation Telephone Number: _____

5. I understand that to the extent of any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

6. I understand that the reason for the use of disclosure (as applicable) is for the purpose of:

□ **Continuing Medical Care** □ **Insurance** □ **Legal** □ **SSI Disability Appeal** □ **Billing/Claims** □ **School**
□ **Patient Request** □ **Research** □ **Employment** □ **Other (Specify):** _____

7. I understand that **Regional Digestive Consultants, P.A.** will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, **Regional Digestive Consultants, P.A.**, will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, **Regional Digestive Consultants, P.A.** will not provide the treatment if I am unwilling to sign this authorization form.

8. I understand that I may revoke this authorization by sending a written request for revocation to **Regional Digestive Consultants, P.A.'s** privacy officer. If I revoke this authorization, **Regional Digestive Consultants, P.A.** will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when **Regional Digestive Consultants, P.A**. discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

9. I understand that **there may be a fee associated with the release of my medical information**.

10. I understand that **this authorization will expire in 12 months from the date signed unless I indicate otherwise here**. _____

11. I, the undersigned, have read the above and authorize to disclose such information as herein contained. I hereby release and hold harmless the above named facility from all liability and damages resulting from unlawful release of my protected health information.

_____ _____ _____
Signature of Patient or Authorized Representative **Date** (mm/dd/yyyy) **Relationship to Patient** (eg. Self, POA)

Reason Patient is unable to sign release: □ **Minor** □ **Deceased** □ **Other**: _____
(Please specify and provide legal documentation as needed.)