AUSTIN REGIONAL CLINIC

Authorization for Use of Disclosure of Protected Health Information **FROM** Austin Regional Clinic

***ALL** sections must be complete to be a valid authorization*

Section I – Patient Information:

Patient Legal Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

Section II – Release Information to:

I hereby authorize Austin Regional Clinic (ARC), or a business associate working on their behalf, to release my medical record information to**:

☐ Mail Copies to: ☐ Electronically Deliver to: ☐ Hold for Patient Pickup ☐ Discuss Medical Information with:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____ Email: _____

Section III – Purpose of Request:

Purpose of Request: ☐ Personal ☐ Continuing Care (second opinion or refer to specialist) ☐ Insurance ☐ Legal

☐ Transfer Out (Reason? _____) ☐ Other: _____

Section IV – Information to be Released *(Mark all that apply)*:

Service Dates *(Optional)* from: _____ to: _____ Clinic and/or Physician/Advanced Practice Clinician *(Optional)*: _____

- ☐ 2 year abstract (includes 3-6 months of diagnostics)
- ☐ Lab Reports
- ☐ Current Medications List
- ☐ Diagnosis Findings (procedure reports, EKGs, etc)
- ☐ Billing Information
- ☐ Other: _____
- ☐ Progress Notes
- ☐ Imaging Reports
- ☐ Problem List
- ☐ Immunizations
- ☐ All Health Information

Some requests are subject to fees – see ARC Release of Information Fee Explanation

Section V - Authorization to Release Protected Information

Initials are required to release the following information:

- ☐ HIV/AIDS Tests & Related Information* _____
- ☐ Hepatitis C Tests & Related Information* _____
- ☐ Mental Health Treatment _____
- ☐ Genetic Testing Information* _____
- ☐ Alcohol and/or Substance Abuse Treatment* _____

I specifically authorize ARC to disclose my Protected Health Information as described on this form to the recipients listed above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I understand that ARC is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or healthcare operations. I have read the authorization and understand what information will be used or disclosed, who may use or disclose this information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms listed above.

- **If the patient is 18 year of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older but is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority below and include documentation of your relationship.
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship below. By signing, **I hereby state that my parental rights have not been revoked by a court of law.**

_____ _____

Patient's Signature Date*

_____ _____

Parent/Legally Recognized Representative's Signature Date*

_____ _____

Parent/Legally Recognized Representative's Printed Name Relationship to Patient

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise: You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that ARC has already completed action on it.

** The information released pursuant to the Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws.

1CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.