Doctors Hospital at Renaissance
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Printed Name: _____ Date of Service (s) _____

Complete Address: _____

City _____ State _____ Zip Code _____

Patient's Birthdate: _____ Patient's Social Security Number: _____

Home Phone Number: (___) _____ Work Phone Number: (___) _____ Cell Number: (___) _____

• I hereby authorize **Doctor's Hospital at Renaissance** to disclose records obtained during the course of my evaluation and/or treatment to:

Name: _____

Address: _____

(Name and address of person or organization to which disclosure is to be made)

Phone #: _____ Fax #: _____

Type of Access Requested: ☐ Copies of Record ☐ Review of Record

OR

• I hereby authorize _____ to disclose records obtained during the course of my evaluation and/or treatment to: Doctor's Hospital at Renaissance; 5501 S. McColl: Edinburg, Texas 78539

(Name and address of person or organization to which disclosure is to be made)

Phone #: _____ Fax #: _____

Type of Access Requested: ☐ Copies of Record ☐ Review of Record

Selected Portions of PHI as marked:

- ☐ Cardiac Studies
- ☐ Consult Report(s)
- ☐ Discharge Summary
- ☐ EKG's
- ☐ Emergency Room Record
- ☐ Face Sheet
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Medication Record
- ☐ Nursing Notes
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Psychological Record(s)
- ☐ Psychiatric Record(s)
- ☐ Radiology Reports/ FILMS
- ☐ Rehab Services
- ☐ Type: _____
- ☐ Other _____

Billing Office: _____

_____

_____(Initials) I___Do (or) ____ Do Not consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:

_____

List the purpose(s) for the release or disclosure of Protected Health Information:

_____

_____

_____

Authorization For Release of Protected Health Information

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This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the Hospital's Health Information Management (Medical Records) Department at (956) 362-3448.

This consent shall become invalid and expire 180 days from the date of signature.
Expiration date: _____ or Expiration Event: ☐ none, or ☐ **define:** _____
If no expiration date indicated, this consent shall become invalid and expire 180 days from the date of signature.

I understand that the Protected Health Information released by this Authorization may possibly be re-disclosed by the facility/person that receives the requested information, and therefore such information would no longer be protected by the HIPAA Privacy Rule.
I hereby release **Doctor's Hospital at Renaissance** from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service and/or electronic facsimile in accordance with Hospital's facsimile policy.

I understand that I have the right to receive a copy of this authorization.
_____Copy of authorization received.

I have read that Doctors Hospital at Renaissance will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.

I have read the above or have had it read to me and authorize the disclosure of the Protected Health Information as stated.

Signature: _____ Date: _____ Time: _____
(Signature of Patient I Legal Guardian or Representative)

If signed by other than patient, indicate relationship:

_____

Witness: _____ Date: _____ Time: _____

**** Authorization representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.***

Employee assisting with Release of Protected Health Information request _____
Initials

Prohibition of Redisclosure: This information has been disclosed to you from records whose Confidentiality is protected by Federal Law. You are prohibited form making any further disclosure of it without the specific written consent of the person to whom it pertains.

OFFICE USE ONLY

Received By: _____

Received Date: _____ Received Time: _____