BAPTIST HOSPITALS OF SOUTHEAST TEXAS
AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHI

1. I, ____, authorize Baptist Hospitals of Southeast Texas to:
   ❒ use (obtain) or ❒ disclose the following protected health information from the record(s) of:
   Name: ______________________________________ DOB: ____________ SS#: ______________
   Telephone Number: ____________________________ Date of Service: ______________________
   Address (city/state/zip): ____

2. I understand that copies of the protected health information will be released to: ❒ Patient ❒ Hospital
   ❒ Insurance Company ❒ Attorney ❒ Other: ____

   ❒ Picked up Name of recipient: ______________________________________
   Name of company: ______________________________________
   ❒ Sent to Address: ______________________________________
   City, state, zip code: ______________________________________
   Telephone number: ______________________________________
   ❒ Faxed to Facsimile number: ______________________________________

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 history of drugs or alcohol abuse, or mental or behavioral health psychiatric care.

4. The information to be used or disclosed:
   ❒ Complete medical record ❒ Complete medical record excluding: ______________________________
   ❒ Face Sheet ❒ History and Physical ❒ Discharge Summary ❒ ER Record
   ❒ Consultation Report ❒ Operative Report ❒ Progress Notes
   ❒ Test Results: (Specify): ____
   ❒ Other: ____

5. I request that my information be provided in the following format:
   ❒ Hardcopy (paper record) ❒ Electronic Media (PDF format)

6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal or Texas privacy regulations, the information described above may be redisclosed and no longer protected by Federal and/or Texas privacy regulations.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that Baptist Hospitals of Southeast Texas may not condition treatment on my completion of this authorization form.

8. I understand this authorization will expire in six months on (check and complete on):
   ❒ Date: ____/____/20__, OR
   ❒ On the happening of the following event that relates to me or the purpose of use or disclosure:

   I also understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. You must write to Privacy Officer at the appropriate address reflected in the hospital's Notice of Privacy Practices.

The purpose of the use and disclosure is: (not required if requestor is the patient) ________________________
____

____________ ____/____/________ ____
Time Date Signature of Patient or Patient's Representative

______________________________________ ______________________________________
Printed Name of Patient's Representative Relationship to Patient

____Legal
Authority (supporting documentation required – copy of power of attorney,etc.)