

**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

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

