Authorization for Use and Disclosure of Protected Health Information (PHI)

Information Regarding Patient for Whom Authorization is Made:

Patient:_____

DOB:_____ Phone : _____

Address:_____

City/State/Zip:_____

I authorize the following to disclose the individual's protected health information	**Who can receive and use the health information**
Name:_____	PROCARE INTERNAL MEDICINE ASSOCIATES
Office Name:_____	10823 Town Center Drive
Address:_____	San Antonio, Texas 78251
City/State/Zip:_____	210.509.7462 phone
Phone #:_____	210.509.7464 fax
Fax #_____	

Reason for disclosure (choose those that apply)

_____ Treatment / continuing medical care
_____ Billing or claims
_____ Legal Purposes
_____ School
_____ Other _____
_____ Personal use
_____ Insurance
_____ Disability Determination
_____ Employment

What information can be released. Complete the following by indicating those items that you want disclosed.

_____ All health information
_____ Physician's Orders
_____ Progress Notes
_____ Lab Results
_____ Past / present medications
_____ History/physical exam
_____ Patient Allergies
_____ Discharge Summary
_____ Billing information
_____ Past / present medications
_____ Consultations
_____ Immunizations
_____ Diagnostic test reports
_____ Radiology reports & images
_____ Operation reports

Your initials are required to release the following information:

_____ Mental health records (excluding psychotherapy notes)
_____ Genetic information (including genetic test results)
_____ Drug, alcohol, or substance abuse records
_____ HIV/AIDS test results / treatment

The individual signing this form agrees and acknowledges as follows:

(1) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(2) Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month _____ Day _____ Year _____.

(3) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time in writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken on this authorization.

(4) **Special Information:** This authorization may include disclosure of information relating to **DRUG**, **ALCOHOL** and **SUBSTANCE ABUSE**, **MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initialed the corresponding lines in the box above. I specifically authorize release of such information to the person or entity indicated herein.

(5) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State privacy laws.

Signatures:

_____ _____
Patient, guardian or legal representative Date

_____ _____
If legal representative, relationship to patient Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance above, and mental health treatment.