TEXAS OCCUPATIONAL MEDICINE INSTITUTE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____(print name) authorize the following health care provider and/or organization to disclose and/or use the following protected health information to the designated person and/or organization for the purpose(s) listed below.

Information disclosed by:	**Information received by:**
_____ (Name of health care provider/organization) _____ _____ (Address) _____ _____ (Facsimile number) (Phone number)	_____ (Name of person or organization) _____ _____ (Address) _____ _____ (Facsimile number) (Phone number)
Disclose the following information: ____Medical record ____ Billing record ____ Other: (please specify) **___ To be mailed** **____ To be picked up by _____** **___ To be sent by facsimile**	**The information is disclosed for the following use(s):** _____ _____ _____

I do ___ do not ___ consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.
I do ___ do not ___ consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV/AIDS.
I do ___ do not ___ consent to the disclosure of substance/alcohol abuse evaluation/treatment.

This authorization shall expire: _____
(expiration date or event)

I understand the following:
1. I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization or if authorization was obtained as a condition of obtaining insurance coverage) by sending a written revocation to the health care provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or my eligibility for benefits will not be affected if I do not sign this Authorization.
3. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
4. I am entitled to receive a copy of this signed authorization.

_____ _____ _____
(Signature of the authorizing individual) (Date of birth) (Date signed)

_____ _____
(Address) (Contact phone number/s)

_____ _____
(Signature of personal representative with description of authority to act on behalf of the patient) (date signed)