

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

<b>Section A: This section must be completed for all Authorization</b>					
<b>Patient Name:</b>		<b>Birth Date:</b>		<b>Social Security No. (optional):</b>	
<b>Requestor Name:</b>					
<b>Requestor Company Name (if applicable):</b>					
<b>Requestor Address:</b>					
<b>City:</b>			<b>State:</b>		<b>Zip:</b>
<b>Requestor Work Phone:</b>			<b>Requestor Home Phone:</b>		
This authorization will expire on the following: (Fill in the Date or the Event but not both.) <b>Date:</b> _____ <b>Event:</b> _____ <b>Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.</b>					
<b>Purpose of disclosure:</b>					
<input type="checkbox"/> Methodist Hospital <input type="checkbox"/> Methodist Specialty & Transplant <input type="checkbox"/> Metropolitan Hospital <input type="checkbox"/> Northeast Methodist <input type="checkbox"/> Methodist Ambulatory Surgery Hospital <input type="checkbox"/> Stone Oak Methodist (You must submit a separate patient authorization for each facility checked)					
<b>Description of information to be used or disclosed</b>					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> Entire Record <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Medication Reports		<input type="checkbox"/> Pathology Reports <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
<u>If this authorization is for disclosure of genetic information, please describe:</u>					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
<b>Section B: Is the request of PHI for the purpose of marketing?</b>					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, describe:					
<b>Section C: Signatures</b>					
I have read the above and authorize the disclosure of the protected health information as stated.					
<b>Signature of Patient/Patient Representative:</b>				<b>Date:</b>	
<b>Print Name of Patient/Patient Representative:</b>				<b>Relationship to Patient:</b>	

Fax back to:    **Methodist Hospital at (210) 575-6292, Methodist Specialty and Transplant at (210) 575-8312 Metropolitan Hospital at (210) 757-2160,**  
**Northeast Methodist at (210) 757-8431, MASH (210) 575-5193, Stone Oak Methodist (210) 638-3884**

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