

Section A: This section must be completed for all Authorizations

Patient Name: _____		Birth Date: _____	
Provider's Name: Methodist Stone Oak Hospital		Recipient's Name: _____	
Provider's Address: 1139 E Sonterra Blvd San Antonio, TX 78258 210-638-2900		Phone Number: _____	Fax Number: _____
Address: _____		City: _____	State: _____
		Zip: _____	
Request Delivery (If left blank, a paper copy will be provided): <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media, if available (e.g., USB drive, CD/DVD, email) NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).			
Email Address (If email checked above. Please print legibly): _____			
This authorization will expire on the following: (Fill in the Date or the Event but not both.)			
Date: _____		Event: _____	

Purpose of disclosure: _____

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record		<input type="checkbox"/> Operative information		<input type="checkbox"/> Labor/delivery summary	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cardiology Tests		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm strips		<input type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing information		<input type="checkbox"/> UB-04:	
<input type="checkbox"/> Lab/Pathology Tests		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> ER information		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

- 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 effect 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.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? Yes No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? Yes No

If yes, describe: _____

May the recipient of the PHI further exchange the information for financial remuneration? Yes No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative: _____	Date: _____
Print Name of Patient's Representative: _____	Relationship to Patient: _____

Fax to: CIOX 210-581-4921

Methodist Specialty and Transplant Hospital, Metropolitan Methodist Hospital, Northeast Methodist Hospital, and Methodist Texsan Hospital are campuses of Methodist Hospital.



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