Them to Us

Huntsville Pediatric and Adult Medicine Associates

Authorization to Disclose Health Information

Patient Name: ______________________________ Date of Birth: ________________________

1. I authorize the use or disclosure of the above named individual's health information as described below from the following individual or organization:

Physician or Facility name: ____

Address: ____

City, State, and Zip: ____

Phone and/or Fax number; ____

2. The type and amount of information to be used or disclosed is as follows:
   - ❑ entire record
   - ❑ immunization record
   - ❑ growth charts
   - ❑ physician's progress notes
   - ❑ laboratory results
   - ❑ x-ray and imaging reports
   - ❑ consultation reports from (doctor's names) ________________________
   - ❑ other (please specify) ____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:

Huntsville Pediatric and Adult Medicine Associates
P.O. Box 8570
Huntsville, TX 77340
Phone: (936) 295-8000
Fax: (936) 294-9131
For the purpose of ____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the administrator of HPIMA. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the administrator of HPIMA.

____ ____________________________

Signature of Patient or Legal Representative Date

____ ____________________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness