Texas Diabetes and Endocrinology, PA

Authorization to Release Protected Health Information

Texas Diabetes & Endocrinology is authorized by me to obtain or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Texas Diabetes & Endocrinology and/or the specified entity to obtain or disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

Patient Name: _____ **Date of Birth:** _____

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record:**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

☐ Alcohol & Drug Abuse Treatment ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
☐ Mental & Behavioral Health (other than psychotherapy notes) & Developmental Disability Treatment
☐ Genetic Information (including, but not limited to, Genetic Test Results)

(NOTE: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

b. My demographic information (check "All" or those that apply):

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other_____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

c. Medical Data/Information as related to (check all that apply):

☐ Specific condition(s)/service(s):_____
☐ Specific medication(s):_____
☐ Alcohol & Drug Abuse Treatment: _____
☐ Mental & Behavioral Health (other than psychotherapy notes) & Developmental Disability Treatment:_____
☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):_____
☐ Genetic Information including, but not limited to, Genetic Test Results: _____
☐ Other: _____

2. Please release the above information from:

Name/Entity: Texas Diabetes & Endocrinology Specialty:_____
Address: 6500 N. Mopac BLDG3, STE. 200 Austin, Texas 78731
Telephone: (512)458-8400 Fax: (512)372-1074
Email:_____

3. Please release the above information to:

Name/Entity:_____ Specialty:_____
Address:_____
Telephone:_____ Fax:_____
Email:_____

4. **Method of release:** ☐ Mail ☐ Fax ☐ CD ☐ Email (please also complete and return an Email Consent Form)

5. **Purpose(s) for disclosure of the information:**

   _____

   _____

6. **Right to revocation**. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. Texas Diabetes & Endocrinology must receive the revocation in writing (and the written revocation must include:

   a. My name and address,
   b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
   c. My desire to revoke this authorization, and
   d. The date of the revocation, and my signature.

   ALL written revocations must be sent to:

   Misha Diden
   6500 N Mopac, Bldg 3, Suite 200
   Austin, Texas 78731
   512-458-8400 phone

7. **This authorization shall expire on _____.** After this date/event, Texas Diabetes & Endocrinology can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

8. **I fully understand and accept the terms of this authorization.**

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Name of Representative (if applicable) **Description of Personal Representative's Authority**

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on _____.
☐ Patient has been provided with a copy of the signed authorization.