

# Authorization for Use and Disclosure of Protected Health Information



Medical Center of McKinney

Medical Record/Health Information Management Department  
4500 Medical Center Drive      phone: (855) 867-5760  
McKinney, TX 75069              fax: (469) 484-2006

I give **Medical Center of McKinney** permission to release my protected health information to:

**NAME OF PERSON OR FACILITY RELEASING INFORMATION TO:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date (s) of Treatment: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Information to be released:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Discharge Summary            | <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Operative Report    | OTHER:                                       |
| <input type="checkbox"/> Laboratory Reports           | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> EKG/ECHO            |  |
| <input type="checkbox"/> Shot Records                 | <input type="checkbox"/> Progress Notes       | <input type="checkbox"/> X-Ray Reports       | <input type="checkbox"/> X-Ray Films/Imaging |
| <input type="checkbox"/> Senior Health Record         | <input type="checkbox"/> Basics/Abstract      | <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Occ Health Records  |
| <input type="checkbox"/> Complete Record              | <input type="checkbox"/> Pathology Report     | <input type="checkbox"/> ER Records          | <input type="checkbox"/> Itemized Bill       |
| <input type="checkbox"/> OTHER: Please specify: _____ |   |  |  |

**The information being released from my medical records is for the following purpose:**

- |   |  |                                   |  |
|---|--|-----------------------------------|--|
| <input type="checkbox"/> Continued Medical Care | <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Attorney | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Patient Request        |  |                                   |  |
| <input type="checkbox"/> OTHER: _____           |  |                                   |  |

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Record Release:**

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or or treatment, I agree to release. Check one: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Initials

**Time Limit & Right to Revoke Authorization:**

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Facility Privacy Official at the above address. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that time or unless otherwise specified as follows:

**Re-disclosure:**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA) Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative:**

I understand that **Medical Center of McKinney** may not condition my treatment whether I sign this authorization form. I authorize **Medical Center of McKinney** to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for photo static copies.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

Authority to sign if not the patient (documentation of authority required) \_\_\_\_\_

Identity of requestor verified by: \_\_\_\_ Photo ID \_\_\_\_ Matching Signatures \_\_\_\_ Verified by \_\_\_\_ Initials