

### Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

**I authorize The Medical Center of Southeast Texas to disclose protected health information to:**

Name \_\_\_\_\_ Phone/Fax Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Call this phone number when records are available for pick up at hospital \_\_\_\_\_

**PURPOSE FOR USE/DISCLOSURE**

Approximate date(s) of service to be used/disclosed \_\_\_\_\_

**INFORMATION TO BE USED / DISCLOSED**

- |   |  |
|---|--|
| <input type="checkbox"/> Emergency Room Record      | <input type="checkbox"/> Pathology report        |
| <input type="checkbox"/> Discharge summary          | <input type="checkbox"/> Lab reports             |
| <input type="checkbox"/> History and Physical       | <input type="checkbox"/> Radiology reports/films |
| <input type="checkbox"/> Operative/procedure report | <input type="checkbox"/> EKG report(s)           |
| <input type="checkbox"/> Consultation report(s)     |  |
| <input type="checkbox"/> Other _____                |  |

**\*Specific Authorization to Disclose Sensitive Records\***

**I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: (please check and initial)**

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol and/or drug abuse records Initials _____        | <input type="checkbox"/> Psychiatric records Initials _____  |
| <input type="checkbox"/> Sexually transmitted disease information Initials _____ | <input type="checkbox"/> HIV/AIDS information Initials _____ |

\*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that The Medical Center of Southeast Texas has already relied on this authorization.
  - I understand that I may revoke this authorization by sending or faxing a written notice to the Privacy Officer, at The Medical Center of Southeast Texas, 2555 Jimmy Johnson Blvd., Port Arthur, TX 77640 or fax 409-853-5483, stating my intent to revoke this authorization.
  - Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing and dating this form, unless otherwise documented here: \_\_\_\_\_
  - I understand that The Medical Center of Southeast Texas may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
  - I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a "covered entity".
- If box is checked, the hospital will receive direct or indirect financial compensation in connection with the use or disclosure of your information for marketing purposes.

Signature (Patient or Patient's Legal Representative) \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Legal Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.**



Account Number:	MR Number:
Patient Name:	
Admit Date:	



2555 Jimmy Johnson Blvd. - Port Arthur - Texas 77640  
(409) 724-7389

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
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Allergies: \_\_\_\_\_

Attending Physician Name: \_\_\_\_\_