Texas Vista Medical Center

A STEWARD FAMILY HOSPITAL

Steward®

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 Texas Vista Medical Center 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

- ☐ Emergency Room Record
- ☐ Discharge summary
- ☐ History and Physical
- ☐ Operative/procedure report
- ☐ Consultation report(s)
- ☐ Other _____
- ☐ Pathology report
- ☐ Lab reports
- ☐ Radiology reports/films
- ☐ EKG report(s)

Specific Authorization to Disclose Sensitive Records I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: (please check and initial)

- ☐ Alcohol and/or drug abuse records *Initials* _____
- ☐ Sexually transmitted disease information *Initials* _____
- ☐ Psychiatric records *Initials* _____
- ☐ 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 Texas Vista Medical Center 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 Texas Vista Medical Center, 7400 Barlite Boulevard, San Antonio, TX 78224 or fax 210-921-3357, 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 Texas Vista Medical Centerl 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 "covered entity" protected by the Federal privacy law, if the recipient is not.

☐ 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.