

Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name _____ First _____ Middle _____

Address _____ City _____ Stat _____ Zip _____

Social Security Number _____ Date of Birth _____ Phone _____

I authorize Odessa Regional 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

- | | |
|---|--|
| <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 Odessa Regional 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 Odessa Regional Medical Center, 520 East 6th Street, Odessa, TX 79761 or fax 432-582-8810, 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 Odessa Regional Medical Center 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.

