All sections must be completed for a valid authorization.

Patient Name:	Birth Date:	Last 4 Digits SSN (optional):
Patient Alias(s):	**Patient Contact Number:**	
Recipient's Name:	**Recipient's Phone:**	**Recipient's Fax:**
Texas Orthopedic Hospital	**713.383.5354**	**713.848.8700**

Recipient's Address (City, State, Zip):
7401 S. Main, Houston, TX 77030

Request Delivery (If left blank, a paper copy will be provided): ☑ **Paper Copy** ❑ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)**
❑ **Encrypted Email** ❑ **Unencrypted Email**
NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

Purpose of disclosure: **Continuation of Care**

Is this request for psychotherapy notes? ❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☑ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
❑ Entire medical record		❑ Clinical Test(s)		**Confidential Information**	
(or Portions)		❑ Medication Sheets		❑ HIV Testing	
❑ Abstract ***(most common)***		❑ ED Information		❑ HIV & AIDS Documentation	
❑ Physician Orders		❑ Admission Form		❑ Psychiatric Documentation	
❑ Physician Progress Notes		❑ Operative Documentation		❑ Alcohol & Drug Abuse	
❑ Physician Dictated Reports		☑ Other:_____		Documentation	

I hereby authorize the entity marked below to release records to the recipient party designated above.

☑ Other _____

This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:

Expiration Date: **or** **Expiration Event**:

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer by protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Unless I specifically mark below that I do not consent, I am expressly consenting to the release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, genetic information, or such disclosure shall be limited to the following specific types of information: I DO NOT CONSENT [ ]

Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ❑ Yes ☑ No
If yes, the health plan or health care provider must complete below, otherwise skip to signature.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ❑ Yes ☑ No
If yes, describe:_____

May the recipient of the PHI further exchange the information for financial remuneration? ❑ Yes ☑ No

I have read the above or had it read to me and I authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative: **Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*	**Relationship to Patient:**

Identification Verified by:_____ ❑ State Issued Photo Identification ❑ Other_____

EDEMF8169