REQUEST FOR ACCESS AND AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

AdventHealth Rollins Brook
608 North key Avenue/ PO Box 589
Lampasas, TX 76550
Tele: (512)564-2208 Fax: (512) 564-2286

Patient Name:	**Medical Record #**
Patient Address: _____ **Street** **Apt #** **Phone #** _____ **City** **State** **Zip Code**	**Date of Birth:** **Today's Date:**

I hereby request AdventHealth Central Texas HIM Department to (*please check all boxes that apply*):

- ☐ Provide me with access to the protected health information specified below
- ☐ Provide me with copies of the protected health information specified below (circle format you would like: photocopy, electronic or other (if available) _____).
- ☐ Disclose my protected health information to the individual(s) specified below
- ☐ Provide me with a summary of my protected health information at a cost of ($ _____).

The purpose of this request:

- ☐ At my request
- ☐ Other (describe) _____

The description of the specific protected health information to be accessed and/or disclosed:

- ☐ My Medical Records for the Admission/Discharge Dates of:_____
- ☐ Complete Medical Record
- ☐ Discharge Summary (ies)
- ☐ Operative Report(s)
- ☐ Pathology Report(s)
- ☐ History and Physical(s)
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Consultation(s)
- ☐ Psychiatric Evaluation
- ☐ Psychological
- ☐ Psychosocial Assessment
- ☐ Other (Specify)_____
- ☐ My Billing Records
- ☐ Any other personally identifiable information used by **AdventHealth Rollins Brook** to make medical decisions about me. (Please describe) _____

I authorize AHCT's HIM Department to disclose the protected health information specified above to:

Name _____

Address _____

City _____ State_____ Zip Code_____

Phone Number _____ Fax Number _____

IHRLSINFO

Affix Patient Label Here

I have read and understand the following statements:

I understand that if I request a copy of the protected health information specified herein or agree to a summary or explanation of such information, AH may impose a reasonable, cost-based fee for such access.

I understand that if I am denied access to all or a portion of my protected health information, the protected health information that I have been denied access to may not be disclosed as authorized in this Form. I understand that the protected health information specified above may include mental health, substance abuse (e.g., drugs, alcohol) and/or HIV/AIDS status information, diagnostic and treatment records.

IF I DO NOT WANT THIS PROTECTED HEALTH INFORMATION DISCLOSED, MY OPTION IS NOT TO SIGN THIS FORM.

I understand this Form is revocable upon written notice to AHCT's HIM Department at 2201 South Clear Creek Road, Killeen, Tx 76549, but if I do, it will not have any effect on any actions AHRB took before it received the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): _____if I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed. I understand that my authorized disclosure of protected health information to the individual specified above carries with it the potential for re-disclosure by such individual and may no longer be protected by the Federal privacy laws.

I understand that signing this Form is completely voluntary and I am signing it under my own free will. I understand that AHRB will not condition treatment, payment, and enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

By signing this Form, I hereby authorize and permit the use and/or disclosure of my protected health information for the limited purpose(s), and in the limited manner, described in this Form. I understand I will receive a signed copy of this Form.

If this Form authorizes the use and/or disclosure of psychotherapy notes, as defined by HIPPA (45 CFR 164.501) it may not be used to authorize the use and/or disclosure of any other protected health information.

I AM THE PATIENT AND I UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FORM/AUTHORIZATION.

_____	_____
Printed Name of Patient	*Printed Name of Witness*
_____	_____
Patient's Signature	*Witness Signature*
_____	_____
Date & Time	*Date & Time*
_____	_____
Name of Insured [if other than Patient]	*Name of Interpreter [if applicable]*

IF THE PATIENT IS A MINOR OR IS SUBJECT TO A GUARDIANSHIP OR HAS A LEGAL REPRESENTATIVE:

I UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FORM ON BEHALF OF THE INDIVIDUAL INDICATED BELOW TO BE THE PATIENT. I HAVE SIGNED MY NAME INDIVIDUALLY AND IN MY CAPACITY AS THE LEGAL REPRESENTATIVE OF THE PATIENT AND I HAVE ATTACHED A COPY OF THE COURT ORDER DESIGNATING ME AS THE GUARDIAN OF THE PATIENT, OR DOCUMENTATION DESIGNATING ME AS THE LEGAL REPRESENTATIVE FOR THE PATIENT.

_____	_____
Printed Name of Patient	*Patient's Parent(s)' Name(s) [if Patient is not my child and if I know their names]*
_____	_____
Printed Name of Legal Representative/Relationship	*Printed Name of Witness*
_____	_____
Legal Representative's Signature	*Witness' Signature*
_____	_____
Date & Time	*Date & Time*
_____	_____
Name of Insured [if other than Patient]	*Name of Interpreter [if applicable]*

Affix Patient Label Here