ATLAS OB-GYN

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient:

_____ _____ _____
Last Name First Name Middle Initial

Other Name Used: _____

Date of Birth: Month _____ Day _____ Year _____

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Telephone # Alt. Telephone # Email (Optional)

I_____, (Patient's Name) authorize Atlas OB-GYN to disclose the following protected health information to the individual(s) listed below:

___ My Health Information is not to be released to anyone

__ Spouse (Name)_____

__ Child(ren (Name(s))_____

__ Other(List Below

1. _____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Telephone # Alt. Telephone # Email (Optional)

2._____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Telephone # Alt. Telephone # Email (Optional)

3._____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Telephone # Alt. Telephone # Email (Optional)

What Information can be disclosed (check all that apply):

___ All Health Information
__ Treatment Records
___ Physician's Orders
___Past/Present Medications
____ Patient Allergies
___ Diagnostic Test Reports
__ History/Physical Exam
__ Discharge Summary
___Radiology Reports & Images
___Surgical Reports
___EKG/Cardiology Reports
__ Progress Notes
__ Lab Report
___Consultation Reports
__ Billing Information
__ Pathology Reports

Other: _____

Reason for Disclosure:

__ Treatment/Continuing Medical Care
__ Insurance
__ School
___ Personal Use
___ Disability
___ Billing or Claims
__ Legal Purposes
__ Employment

Other: _____

_____

Your initials are required to release the following information:

___ Mental Health Records
___ Genetic Information (including Genetic Test Results)
___Drug, alcohol or Substance Abuse Records
___ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaches the age of majority; or permission is withdrawn; or the following specific date (Optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE:_____ _____
Signature of Individual or Individual's Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable):_____
If representative, specify relationship to the individual: __ Parent of minor ___Guardian ___Other

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE:_____ _____

(Signature of Minor Individual) Date

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed. Finally, you may revoke this authorization in writing at any time by sending

written notification to [Atlas OB/GYN, Dr. Mini Sreedevi, Privacy Officer] at 2821 E. President Bush Hwy., Ste 207. Richardson, Texas 75082. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.