AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's PRINTED Name:	**Birthdate:**	**Social Security No**
Address (include city, state, zip):	**Home Phone: ( )** **Cell Phone: ( )**	**Work Phone: ( )**

I hereby authorize Corpus Christi Medical Center to disclose records obtained in the course of my evaluation and/or treatment to: (Name and address of person or organization to which disclosure is to be made)

Name: **Address:**

Phone Number : ( ) **Fax Number: ( )**

Type of Access Requested: _____Copies of Record OR _____ Inspection of records OR _____Release to Media/Marketing
Medical Records: (Entire Record or Selected Portions of PHI as marked below) **(recording, filming, interview, photo)**

Description:	**Date(s)**	**Description:**	**Date(s)**	**Description:**	**Date(s)**
[ ] Entire Records **(or Portions):** [ ] Discharge Summary [ ] Emergency Room Records [ ] History and Physical [ ] Consult Report(s) [ ] Operative Report(s) [ ] Rehab Services Type:_____		[ ] Lab [ ] Imaging/Radiology [ ] Nursing Notes [ ] Medication Record [ ] Psychological Record [ ] Psychiatric Record(s) [ ] Progress Notes [ ] Physician Orders [ ] Pathology Report		[ ] Face Sheet [ ] Cardiopulmonary Report [ ] Immunization Information [ ] Other_____ [ ] **Billing Records *** [ ] Detailed Bill [ ] UB92 *****Forward to the PAD for processing	

_____(**INITIALS**) **I DO [ ] or DO NOT [ ]** consent to 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:_____
_____

List the purpose(s) (including marketing) for the release or disclosure of Protected Health Information:_____
_____

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing the information? [ ]Yes** [ ] No
**If yes, describe the type of compensation:_____

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the Hospital's Health Information Management/Medical Records Department for assistance at 361-761-3705 (Bay Area); 361-761-1425 (Doctor's Regional); 361-767-4326 (Northwest & Northshore).

This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:
Expiration date:_____ or Expiration Event:_____ None:_____, or define:_____

I understand that :

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. I have the right to receive a copy of this authorization. Copy of the authorization received. [ ] _____(Initials)
3. A copy or facsimile (fax) of this authorization **is** as valid as the original.
4. My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.

I hereby release Corpus Christi Medical Center from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service and /or electronic facsimile in accordance with the hospital's facsimile (fax) policy.

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

SIGNED:_____ DATE: _____
(Signature of Patient/Legal Guardian or Representative*)
If signed by other than patient, indicate relationship: _____

Witness: _____ DATE: _____
**Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*

To the Party Receiving this Information: This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.

OFFICE USE ONLY:

Completed by:_____ Date Completed:_____ Copy sent to PAD (date):_____

Medical Record #:_____ Acct.#:_____