PATIENT INFORMATION

PATIENT'S NAME:

ADDRESS:

PHONE NO.: CITY, STATE,ZIP:

DATE OF BIRTH: SOCIAL SECURITY NO.:

I authorize Providence Hospital to disclose/obtain my health care information indicated below from my designated record set:

FACILITY/PERSON TO WHOM PHI WILL BE RELEASED/DISCLOSED/OBTAINED :	PURPOSE OF DISCLOSURE
NAME:	☐ Follow Up Care ☐ Insurance
ADDRESS 1:	☐ Attorney ☐ Personal Use
ADDRESS 2:	☐ Other ** Please Explain:
CITY, STATE, ZIP:	**METHOD OF RELEASE/DISCLOSURE**
PHONE NO.	☐ Mail ☐ Pick Up ☐ Fax Fax Number: ____________

INFORMATION TO BE USED/DISCLOSED: (Check all that apply)

☐ Record Summary	☐ Laboratory Report	☐ Physician Orders	☐ Infectious Disease (including HIV Test Results)
☐ Front Sheet	☐ ER Information	☐ Progress Notes	☐ Consultations
☐ Discharge Summary	☐ Imaging Reports (X-Rays, CT, MRI)	☐ Nursing Information	☐ Complete Medical Record
☐ History/Physical	☐ Mammogram Films	☐ Billing Records	☐ Other: ____________
☐ Operative Report/Procedure	☐ Mammogram and Ultrasound Reports	☐ Medication Records	____________
☐ EKG, EEG, EMG	☐ Ultrasound Films	☐ Pathology	

Date(s) of Service Requested: ____________

THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:

I understand any of the above requested information may contain information that pertains to my diagnosis and treatment for psychiatric or psychological disorders, alcohol/drug (substance) abuse, and may include records which indicate the presence of communicable or venereal diseases, including but not limited to, hepatitis, syphilis, gonorrhea, Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV).

I, the undersigned, understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date ____________). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, Providence Hospital can no longer use or disclose my information for the above purposes without a new authorization. All revocations **will** be sent to the attention of the facility Privacy Official and become effective once received.

I understand that the above information may include records and/or reports from other health care providers involved in my care or treatment. I have read this authorization and understand what will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

NOTE: If PHI is disclosed under your authorization to persons or organizations not subject to federal privacy laws, it may be re-disclosed and no longer protected.

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulation.

SIGNATURE of Patient or Personal Representative ____________ Date ____________ Time ____________ RELATIONSHIP to Patient ____________

WITNESS Signature: ____________ **REASON** Patient is not signing: ____________

FOR OFFICE USE ONLY

MR No.:	ACCT. No.:	DOS:
AUTHORIZATION COMPLETED ON: BY: ____________	AUTHORIZATION VERIFIED BY: ☐ Photo ID ☐ Matching Signature ☐ Other: ____________	☐ PATIENT HAS BEEN PROVIDED WITH A COPY OF THE SIGNED AUTHORIZATION

PICK-UP DATE: ____________ PICK-UP SIGNATURE: ____________ RELEASED BY: ____________

Request & Authorization to Release Medical Information *Form MRPH 05 Initiated: 9.8.16*

16750 Red Oak Dr.
Houston, TX 77090
Phone: 281-453-7970 Fax: 281-453-7906

Place Patient Label Here