AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION (PHI)

Patient's Name:

Social Security No.:

Date of Birth:

Phone No.:

I hereby authorize: _____
[Health Care Provider, Location where exam was performed.]

to disclosed my individually identifiable health information as described below, which may include information concerning Human Immunodeficiency Virus ("HIV") or Acquired Immunodeficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I hereby authorize the above-named health care provider to disclose records obtained in the course of my evaluation and/or treatment, and to send these records by U.S. mail service and/or electronic facsimile to:

Maverick County
500 Quarry Street, Suite 6
Eagle Pass, Texas 78852

Telephone: (830) 773-4377

I understand that Maverick County, is not a "covered entity," as that term is defined by the Health Insurance Portability and Accountability Act ("HIPAA"), and that the information released to Maverick County, may not be protected thereafter by federal and/or state privacy regulations. I further understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I request that the Maverick County, be given access for the purpose of copying records or inspecting records, at the discretion of Maverick County. I further request that Maverick County, be given access to my entire medical records and all medical billing records, without limitation, at the discretion of Maverick County.

Purpose for release or disclosure of PHI: Pursuant to the requisites of TITLE 45, PART 164, SECTION 164.508(c)(1)(iv) of the CODE OF FEDERAL REGULATIONS, I hereby state that the purpose of this disclosure is **"at the request of the individual**."

I understand that this authorization is voluntary, and I may refuse to sign this authorization. I understand that I have a right to receive a copy of this authorization.

This authorization shall expire 365 days from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the medical provider above in writing. I understand that such written revocation must be signed and must be dated later than the date on this authorization. Revocation will not affect any actions taken before the receipt of the revocation.

I expressly intend that this authorization be given in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), Title 45, Part 164, Section 164.508 of the Code of Federal Regulations; Subtitle I, Chapter 181 of the Texas Health and Safety Code; §159.005 of the Texas Medical Practice Act; §201.405 of the Texas Occupations Code; §202.406 of the Texas Occupations Code; §258.104 of the Texas Dental Practice Act; Title 22, Part 9, Chapter 165 of the Texas Administrative Code; Title 22, Part 3, Chapter 80 of the Texas Administrative Code; Title 22, Part 5, Chapter 108 of the Texas Administrative Code; and Title 22, Part 18, Chapter 375 of the Texas Administrative Code.

A copy or facsimile of this authorization is as valid as the original.

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

_____ _____

[Signature of Patient / Legal Guardian or Representative]* *[Date]*

*If signed by other than patient, indicate relationship and a description of your authority to act for the patient: _____

_____

_____