AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH 45 CFR §164.508-HIPPA

I hereby authorize the City of Helotes to disclose my Protected Health Information (PHI) as contained in the records maintained by the City of Helotes or/and the Helotes Fire Department, including but not limited to highly confidential information concerning communicable diseases, HIV, AIDS, *psychiatric*, chemical or alcohol dependency, laboratory test results, or any other medical treatment. This authorization **does/does not** (please circle selection) include psychotherapy notes.

PATIENT IDENTIFICATION INFORMATION

Account or medical record number _____

Patient's Name: _____
(First) (Middle) (Last)

Social Security Number: _____Date of Birth: _____

Name and Address of Recipient: _____

The release of the materials listed is being authorized for use as evidence in a legal proceeding involving this patient. You understand that such information cannot be released without the patient's specific consent. **You are authorized to comply with an original or copy of this document.**

DESCRIPTION OF INFORMATION TO BE RELEASED

The matters to be released pursuant to this authorization are as follows: any and all medical or reports, x-rays (if requested), diagnostic studies, laboratory slides (if requested), clinical abstracts, histories, charts, admission sheet, system history or system review, summary sheet, medical service sheet, nurse's notes, discharge notes, chronological survey, consultant reports, any patient records not located in the medical record library (such as emergency room records), any *counseling* records, and any correspondence, including any handwritten or typed notes of or from any nurse, doctor, physician, surgeon, or any other person, and any other information, documents and opinions relevant to past, present and future, physical, mental and/or emotional conditions, treatment, or hospitalization.

This authorization includes the release of documents in your possession whether or not created in your office or by another healthcare provider.

I understand that this authorization will expire on _____ (date) or 180 days from the date of this signed authorization, whichever comes first.

I understand that the information released in response to this authorization is subject to disclosure to other parties, and that any other person, firm or entity that releases materials pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the physician, or appropriate healthcare provider. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

You are authorized to comply with an original or copy of this authorization, dated on this the _____ day of _____, 20_____.

_____ _____
Signature of Patient or Patient's Representative/Guardian Date

_____
Printed Name of Patient or Patient's Representative/Guardian

_____
Representative's/Guardian's Relationship to Patient (if the patient is a minor or incapacitated adult.)