PATIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Austin Oaks Hospital 1407 West Stassney Lane, Austin, TX 78745
Phone: 512-440-4800 Email: austinoaksmedicalrecords@uhsinc.com Fax: 512-440-4838

(Patient Name) (Date of Birth) (Date of Hospitalization)

I hereby freely and voluntarily authorize Austin Oaks Hospital to…
(Check one) ____ Release/Disclose records of my health information to:
____ Obtain records of my health information from:

Individual, Facility, Organization ( ) Telephone Number

Address ( ) Fax Number

City, State, Zip

The purpose for this disclosure is: _____

The information to be released includes: **(mark or circle documents)**

- ☐ Discharge Summary
- ☐ Admission Psychiatric Evaluation
- ☐ History and Physical
- ☐ Psychological Testing
- ☐ Treatment Plans
- ☐ Lab, X-Rays, EEG, EKG
- ☐ Verbal exchange of information
- ☐ Other_____

My medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that I have the right to revoke this authorization at any time by giving written notice to the Austin Oaks Hospital Privacy Officer, except to the extent that Austin Oaks Hospital has already taken action in reliance on it. This authorization will expire in **180 days** or as otherwise specified herein: _____; whichever comes first.

Patient Signature ***Patient must sign release regardless of age if alcohol and/or drug treatment is involved.*** Date

Parent / Legally Authorized Representative Signature Relationship Date

Staff Signature Title Date