I HEREBY AUTHORIZE ❒ **Nix Healthcare** ❒ _____

Name of Hospital / Facility from which you are requesting

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FROM THE RECORD OF:

PATIENT NAME: _____ **TELEPHONE # :**_____

DATE OF BIRTH :_____

Covering the period(s) of hospital from:

DATE(S) OF ADMISSION/DISCHARGE: _____

INFORMATION WILL BE RELEASED TO:_____

ADDRESS: _____ **FAX:** _____ **PHONE#:**_____

I HEREBY AUTHORIZE THE FOLLOWING INFORMATION TO BE DISCLOSED:

❒ Discharge Summary
❒ Discharge Instructions
❒ History & Physical
❒ Psychotherapy Notes
❒ Other : _____
❒ Operative Report
❒ Lab Results
❒ Radiology Reports
❒ Psychiatric Evaluation
❒ Progress Notes
❒ Complete Health Record(s)
❒ Transfer Instructions

PURPOSE(S) OF DISCLOSURE: ❒ Continued Medical Care ❒ Legal Purposes ❒ Insurance ❒ Other: _____

I hereby also consent to the release of the following information, which may have specific statutory protection:

- Information about substance abuse and treatment; mental health information, AIDS/HIV test results, diagnosis, treatment or drug test results, and healthcare information received from another healthcare institution.

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that the Nix Healthcare System may not condition treatment on my completion of this authorization form.

I understand that I may revoke this authorization in writing at any time except to the extent that Nix Healthcare System has already relied on this information. I understand that to revoke this authorization I must do so in writing and present it to the Medical Record Department. **Unless otherwise specified, this authorization shall expire 180 days from the date of signature.**

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Legal Representative Date