



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

BSA Health System
1600 Wallace Blvd Amarillo, Texas 79106

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

SOCIAL SECURITY NUMBER: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name BSA Hospital
Address 1600 Wallace Blvd
City Amarillo State TX Zip Code 79106
Phone (806) 212-5452 Fax (_____)

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____)

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abstract | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
 _____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment - Sexually Transmitted Disease Test Results

***** Records requested as _____ Paper _____ CD

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

** Fee is waived when releasing information directly to a treating physician or health care facility.**

SIGNATURE X _____ DATE _____
Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ DATE _____
Signature of Minor Individual





MRO

PO Box 61507 • King of Prussia, PA 19406 • Phone 888.252.4146 • Fax 610.962.8421

MRO Corporation is the company that handles medical records duplication for Baptist St. Anthony's Health System. Please fill out the authorization form completely, and be sure to sign and date it.

The processing time for records is 5-7 business days after receipt of payment, depending on the type of records requested and the time frame. If the records are for a doctor's appointment, please provide the name of your doctor, the address, phone and fax number. MRO will send the records directly to your doctor at no charge.

Please note that there is a charge for personal medical records requests.

Paper Pages @ \$0.13 per page (copying from paper charts)

Electronic Pages @ \$0.11 per page (copying from computer chart)

Once the records are ready, you will be notified via mail. Please review the invoice for payment information. Payment may be made by check, credit card, or money order. Your requested records will then be mailed to you. Pre-payment is required.

Please call **888-252-4146 Ext. 1** to check the status of your records, make a payment, or ask any questions.

Records from another facility contained within the requested records will not be released. Those records must be obtained from the facility from which they originated.

Thank you,

MRO Corporation