



# 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 (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

## 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 ( 806 ) 212-2678

## 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 \_\_\_\_\_

## WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

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

**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) \_\_\_\_\_ Dates of service requested: From \_\_\_\_\_ To \_\_\_\_\_  
 \_\_\_\_\_ Drug, Alcohol, or Substance Abuse Records \_\_\_\_\_ Genetic Information (including Genetic Test Results)  
 \_\_\_\_\_ 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





888.252.4146  
sales@mrocorp.com  
www.mrocorp.com

**MRO is the company that handles release of medical records for BSA. As their partner for Release of Information (ROI), it is our pleasure to serve you!**

**Please fill out an ROI authorization form completely, and be sure to sign and date it.**

The processing time for copies of records is 5-7 business days after receipt of payment, depending on the type of records and the dates of service requested. Federal law permits BSA to assess patients a reasonable, cost-based fee for copies of their records. (See 45 CFR § 164.524(c)(4).)

For copies of your records, you may be assessed a fee based on the following fee schedule:

How the PHI is Maintained	Requested Format of PHI	Reasonable, Cost-Based Fee
Electronically	Electronic (Email or CD-ROM)	Flat fee of \$6.50 (inclusive of actual labor, supplies and postage), plus applicable sales tax
Electronically	Paper	\$0.10 per page (\$0.08 per page for actual labor and \$0.02 per page for supplies), plus applicable postage and sales tax
Paper	Paper	\$0.10 per page (\$0.08 per page for actual labor and \$0.02 per page for supplies), plus applicable postage and sales tax
Paper	Electronic (Email)	\$0.08 per page (actual labor), plus applicable sales tax
Paper	Electronic (CD-ROM)	\$0.08 per page (actual labor), plus \$0.22 per CD-ROM/ Mailer (supplies), plus applicable postage and sales tax
Hybrid – Electronic and Paper	Paper	\$0.10 per page (\$0.08 per page for actual labor and \$0.02 per page for supplies), plus applicable postage and sales tax
Hybrid – Electronic and Paper	Electronic (Email and CD-ROM)	Flat fee of \$6.50 (inclusive of actual labor, supplies and postage), plus applicable sales tax

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.

**Please call 610.994.7500 Ext. 1 to check the status of your request, make a payment or ask any questions.**