LIVINGSTON/CLEVELAND PEDIATRICS
400 Ogletree Drive Livingston, TX 77351 #936-328-8812
203 N. College Cleveland, TX 77327 #281-592-6000

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 failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Texas Medical Records Fee Amounts: There will be a charge of $25.00 for the first 20 pages of the record, and $0.50 per page for every copy thereafter. In addition, a reasonable fee my include actual costs for mailing, shipping, or delivery.

NAME OF PATIENT OR INDIVIDUAL

_____
LAST FIRST MIDDLE

Other Name(s) Used: _____

Date of Birth: Month _____ Day _____ Year _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Alternate #:**_____

Email (optional): _____

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

Person/Organization Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Organization Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Changing PCP
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Treatment/Continuing Medical Care
- ☐ 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.

☐ **All Health Information**	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Order	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ 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

☐ CHECK HERE IF YOU WISH TO HAVE THE RECORDS PROVIDED IN ELECTRONIC FORMAT (CD). This is available only for records within Livingston/Cleveland Pediatrics, PA electronic health record system.

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.

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 ☐ Legal 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).

MINOR'S SIGNATURE X _____ **DATE** _____

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Livingston/Cleveland Pediatric Clinic, PA has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154 (d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

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. (Tex. Health & Safety Code §§ 181.154 (b), (c), § 241.153, 45 C.F.R. §§ 164.502 (a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002 (6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3 (aa)).

Health Information to be Released – if "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R §§ 164.502 (a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health with this form, state or federal law allows such access, unless such access is determined by the physician or metal health provider to be harmful to the individual's physical, mental, or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006 (a); 45 C.F.R. § 164.502 (a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are in involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also included that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.F. § 164.522 (a)(1)(vi)).

Authorization for Sale or Marketing Purposes – If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code § 181.152,. 153; 45 C.F.R § 164.508 (a)(3), (4)).

Limitations of this form – This authorization form shall not be used for the disclosure of any health information as it relates to: (1) Health benefits plan enrollment and/or related enrollment determinations (45 C.F. R. § 164.508 (b)(3)(ii); or for research purposes (45 C.F.R. § 164.508 (b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g. 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges – Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.