

Authorization for Disclosure of Protected Health Information

Patient Name: _____
Address: _____

Date of Birth: _____
SS#: _____

I HEREBY AUTHORIZE Todd Swick, M.D., P.A.; 7500 San Felipe, Ste. 525; Houston, TX 77063 (Phone: 713-465-9282; Fax: 713-465-9248) TO DISCLOSE MY PROTECTED HEALTH INFORMATION, AS DESCRIBED BELOW TO (name of receiving entity):

NAME OF ENTITY

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE #

FAX #

INFORMATION TO BE RELEASED:

- | | |
|---|--|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Surgical Reports |
| <input type="checkbox"/> ECG Results (any & all) | <input type="checkbox"/> Developmental Disabilities |
| <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Laboratory Results (any & all) | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Sexual Transmitted Disease | <input type="checkbox"/> Polysomnogram Test |
| <input type="checkbox"/> HIV test results* | <input type="checkbox"/> Multiple Sleep Latency Test |
| <input type="checkbox"/> Alcoholism/ Drug Abuse | <input type="checkbox"/> Maintenance of Wakefulness Test |
| <input type="checkbox"/> Other (please specify): _____ | |

**a list of the statutory exceptions for release of HIV test results without consent is available*

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standard and my health information might be redisclosed without obtaining my authorization. I UNDERSTAND THAT I HAVE RIGHTS TO:

- * RECEIVE A COPY OF THIS AUTHORIZATION
- * REFUSE TO SIGN THIS AUTHORIZATION and that treatment, payment, enrollment in a health plan or eligibility for health are benefits may not be contingent on my signing this authorization
- * REVOKE THIS AUTHORIZATION, except to the extent that the person(s) and or organization listed above already made in reference to this authorization

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL THE FOLLOWING DATES:

X _____ through _____
Signature of patient (or legal representative) Date of signature Last date of service

If signed by a legal representative, relationship to patient: _____

NOT FOR REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Texas Law (Article 4495b, Sec. 5.08) and Federal Regulations (42CFR Part 2). These regulations prohibit you from making any further disclosure, without the specific written consent of the person to whom pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.