HEIGHTS
OBSTETRICS & GYNECOLOGY

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that my provider is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize my provider or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record: (Please NOTE: If you check "my entire record," please SKIP to number 2. Otherwise, please continue with b. and c. below.**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

☐ **b. My demographic information (check "All" or those that apply):**

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

☐ **c. Medical Data/Information as related to (check all that apply):**

- ☐ Specific condition(s):_____
- ☐ Specific professional service(s):_____
- ☐ Specific medication(s):_____
- ☐ Alcohol and Drug Abuse Treatment:*
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment:_____
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):_____
- ☐ Genetic Information including, but not limited to, Genetic Test Results:
- ☐ Other: _____

→ **Please disclose the above information FROM:**

Name/Entity:_____
Address:_____
_____
Phone:_____
Email:_____
Fax:_____

Send TO:

Name:_____
Address:_____
_____
Phone:_____
Email:_____
Fax:_____

I ☐ **do** ☐ **do not authorize this information to be disclosed electronically.**

2. Purpose(s) for disclosure of the information:

3. **Right to revocation.** I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Heights must receive the revocation in writing, and the revocation must include:
   a. My name and address,
   b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
   c. My desire to revoke this authorization, and
   d. The date of the revocation, and my signature.

   Heights OB/GYN will accept written revocations of this authorization via:

   ☐ Certified U.S. mail: 999 E. Basse Rd ste 100 S.A. TX 78209

   ☐ Facsimile at this number: **210-656-6419**

   ALL revocations must be sent to Heights Obstetrics and Gynecology, and are not effective until received.

4. **This authorization shall expire on** _____. After this date/event, Heights OB/GYN can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

5. **I fully understand and accept the terms of this authorization.**

I understand that a reasonable amount of time (not to exceed 15 days) maybe needed to fulfill this request. A fee maybe charged according to TMA guidelines. **The maximum fee will be $6.50 for records requested by the patient (sent/given to the patient). There will be No Charge if records are sent directly to the Healthcare provider.** *Fax numbers for each care center are listed under their logo below.*

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Name of Patient **Date of Birth of Patient**

_____ _____

Name of Representative (if applicable) **Description of Representative's authority to act for patient**

***CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HEIGHTS
OBSTETRICS & GYNECOLOGY