

**PATIENT AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

I understand MCHD is authorized by me to use or disclose my Protected Health Information for a purpose 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 MCHD 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 so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

My entire medical record
(NOTE: This requires an explanation of why it is necessary to disclose the entire record)

My demographic information (*check all that apply*):
 Name Address State/Zip Code only Telephone
 Age Gender Race Other: _____

Medical Data/Information as related to:
 Specific condition(s): _____
 Specific professional service(s): _____
 Specific medication(s): _____
 Other: _____

Other: _____

Name(s) or class of person(s) to whom MCHD may disclose my Protected Health Information:

Purpose(s) for disclosure of the information:

(Note: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

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, MCHD must receive the revocation in writing, and the revocation must include:

- My name, address, and patient number, if applicable,

- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
- My desire to revoke this authorization, and
- The date of the revocation, and my signature.

MCHD will accept written revocations of this authorization via:

- Certified U.S. Mail
- Facsimile at this number: (979) 241-5553.

ALL revocations must be sent to MCHD to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

Should I wish to access my Protected Health Information, such request must be made in writing. I also agree that such access may be provided in summary form. I will provide all reasonable costs.

This authorization shall expire on_____. After this date, MCHD can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Signature of Patient or Patient's Representative

Date

Name of Patient

Patient Identification Number

Name of Representative (if applicable)

Description of Representative's authority to act for patient

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.

Patient has been provided with a copy of the signed authorization.