AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information. This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form. This authorization shall be in effect for one year from the date signed. I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I have read this form and agree to the uses and disclosure 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. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Name:____ **Date of Birth:** ______________________

Address:____ **City** ________ **State** ___ **Zip** _________

Phone Number: ___________________________________ **Alternate Number:** _______________________________

Requesting Information to be sent: □ **FROM** **or** □ **TO**

Clinic or Provider Name: ____

Address:____**City** ________ **State** ___ **Zip** ________

Phone Number: ______________________________________**Fax Number:** _____________________________________

Information to be sent (*to or from*): (*Please mail records if more than 20 pages*)

☐ **Chisholm Trail Pediatrics Georgetown**

600 High Tech Drive

Georgetown, Texas 78626

Ph: 512-930-4776

Fax: 855-299-7012

☐ **Chisholm Trail Pediatrics Forest Creek**

4112 Links Lane #102

Round Rock, Texas 78664

Ph: 512-436-9455

Fax: 855-299-7012

Information to be included:

□ **Immunization Records** □ **Growth Chart** □ **Physical Exam** □ **Labs/X-ray**

□ **Diagnostic Test Results (May include HIV, AIDS, Blood Alcohol, Blood Test Results**

□ **Complete Chart, all of the above** □ **Other:**____

Information Necessary for the following purpose

□ **Continued Patient Care** □ **Insurance** □ **Personal Use** □ **Attorney/Legal** □ **Other** _______________

Signed: ____ **Date:**______________________

Witness: ____ **Date:** ______________________