AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Baylor College of Medicine

Send this Form to: 2 Greenway Plaza Ste. 900 Houston, TX 77046.
Fax (713) 798-1464; Phone (713) 798-5259; E-mail: roi@bcm.edu
Hand delivered authorizations are accepted at the clinic where services were provided
Note: Include copy of valid photo ID with Authorization

ALL SECTIONS MUST BE COMPLETED FOR A VALID AUTHORIZATION		
I Authorize _____ to release or give access to the personal health information of the patient to the recipient both listed below:		
Patient Name:	Date of Birth:	Last 4 SSN (Optional):
Patient Alias(s):	Patient Contact Number:	
Recipient's Name:	Recipients Phone:	Recipients Fax:
Recipient's Address (Street, City, State & Zip):		
Recipient's E-mail (Please print legibly):		

Format Request (If blank, paper will be provided):	☐ Paper	☐ Encrypted Electronic media, if available (USB drive, CD/DVD)			
Deliver: (If blank, paper will be provided):	☐ Mail	☐ BCM MyChart	☐ Fax	☐ Encrypted e-mail	☐ Unencrypted e-mail*

***NOTE**: In the event Baylor College of Medicine is not able to accommodate an electronic delivery as requested, an alternative delivery method will be provided. There is some level of risk that a third party could see your PHI without your consent if you chose to receive delivery by unencrypted e-mail. BCM is not responsible for unauthorized access to the PHI contained in an unencrypted e-mail you requested including any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in unsecure e-mail.

Purpose of Disclosure:	☐ Treatment	☐ Disability	☐ Billing/Claims	☐ Legal	☐Other:

Patient Information Requested:

Is this request for Psychotherapy Notes and/or Diagnostic Testing Results ONLY? ☐ Yes, then these are the only item you may request on this authorization. You must submit a separate authorization for other items listed below. ☐ No, then you may check as many items below as you need.

Description	**Date(s)**	**Description**	**Date(s)**	**Confidential Information****	**Date(s)**
☐ Entire Record		☐ Medication List(s)		☐ HIV Testing	
☐ Visit Notes		☐ Diagnostic Reports		☐ HIV & AIDS documentation	
☐ Labs		☐ Diagnostic Images		☐ Mental Health Notes	
☐ Operative Notes		☐ Billing Statements		☐ Alcohol & Drug Abuse	
☐ Other:				☐ Genetic Testing	

**Confidential Information: You must specifically check each item otherwise it will not be disclosed or released.

Effective Time Period: This authorization is valid until the patient's death, the patient reaching the age of majority or 180 days from the date of signature, whichever is earlier, or upon an Expiration Date or Event (Please list):

SIGNATURE AUTHORIZATION: By signing below, I understand the following:

a. I may refuse to sign this authorization and that it is strictly voluntary
b. I may revoke this authorization at any time be sending a written revocation to the person/organization listed above. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.
c. Any treatment, payment, or my enrollment in any health plan, or my eligibility for benefits will not be affected if I do not sign this Authorization.
d. Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
e. I am entitled to receive a copy of this signed authorization.

I have read the above or had it read to me and I authorize the disclosure of the Protected Health Information and noted above.

Signature of Patient/Legal Representative:	**Date:**
Print Name of Patient's Legal Representative:	**Relationship to Patient:**
	☐ **Self** ☐ **Parent** ☐ **Guardian/Ward** ☐ **Other:**
	Attach documents demonstrating your authority to act for the patient.

A minor's signature is required for release of certain health information, such as information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol or substances able and mental health treatment (Tex. Fam. Code §32.003)

Signature of Minor:	**Date:**