**BRAZOSPORT REGIONAL HEALTH SYSTEM**
**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Patient Name_______________________________________________ Medical Record #________________________________
(Please Print)
Address: _______________________________________________________________ Date of Birth: ______________
Home or Cell #________________________ Wk_________________ SS#_____________________________________________

I hereby authorize Brazosport Regional Health System, 100 Medical Drive, Lake Jackson, Texas 77566; to use and disclose the following protected health information from the medical records of ____________________________________________________________.
Patient Name

To:__________________________________________________ Address______________________________________________

City_____________________________ State_________ Zip Code_____________ Phone #_____________ Fax #________________

For the following purpose: _____________________________________________________________________________________

For treatment dates: ___________________________________________________________________________________________

| Type of Access Requested | Information to be disclosed | | |
|---|---|---|---|
| ☐ Copies of the record | ☐ Abstract/Pertinent Information | ☐ Entire Record | ☐ MD progress notes |
| ☐ Inspection of the record | ☐ Billing Records | ☐ Face Sheet | ☐ Nursing Notes |
| ☐ Computerized access | ☐ Cardiac Studies | ☐ H&P | ☐ Operative/Procedure Report |
| | ☐ Consultation | ☐ Lab | ☐ Radiology |
| | ☐ Emergency Room | ☐ MD orders | ☐ Other ______________________ |

1. ___I DO or ____I DO NOT consent to release information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol and drug abuse or such disclosure shall be limited to the following specific types of information:________________________ ______(Initial)

2. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to (Brazosport Regional Health System, Health Information Management Department, 100 Medical Drive, Lake Jackson, Texas 77566). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ___________(Initial)

3. Unless otherwise revoked, this authorization will expire 180 days (six months) from the date on which it was signed.
   Expiration date________________.

4. I understand once the information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may no longer be protected by federal or state privacy regulations.

5. I understand that my healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.
   ____(Initial)

6. I understand that I have the right to receive a copy of this authorization after it has been signed. Copy of authorization received.
   _______(Initial)

7. I understand that a copy or facsimile of this authorization is as valid as the original. __________(Initial)

I hereby release Brazosport Regional Health System from any and all legal liability and injuries that arise from the release of this information to the party named above. This information may be sent by U.S. Mail, delivery services and/or electronic facsimile in accordance with the hospital's facsimile (fax) policy.

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

Signature of Patient or *Legal Representative______________________________________________ Date_________________________

If signed by legal representative, relationship to patient ______________________________________________________________

Signature of Witness______________________________________________________________________ Date__________________________

*Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.
**White – Original**
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