HOUSTON THYROID & ENDOCRINE Specialists
6624 Fannin Suite 2360
Houston, Texas 77030
713.795.0770

Authorization for the Use and Disclosure of Protected Health Information

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996 and state law, Houston Thyroid and Endocrine Specialists (HTES) is requesting your authorization for use and release of health information. This authorization gives HTES your permission to acquire, use or release specified health information for treatment, payment, and health care operations and other purposes.

1. PATIENT INFORMATION _____ _____
Name (Last, first, middle initial) Date of Birth

2. Type of Request

☐ *My complete medical record(s), except for 2.1 or:*

☐ Discharge Summary ☐ Emergency Room ☐ History& Physical ☐ Consultation reports ☐ Operative Reports

☐ Rehab Services ☐ Laboratory results ☐ Imaging/radiology ☐ Nursing reports ☐ Medication records

☐ Psychological records ☐ Progress Notes ☐ Psychiatric records ☐ Physician orders ☐ Physician progress notes

☐ Billing records ☐ Photographs ☐ Other (Specify) _____

2.1 . _____(initials) ☐ **I DO** or ☐ **I DO NOT** consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information_____ Note: If this section is not completed, records of this type if they exist for this patient will not be released.

3. State the purpose of disclosure
_____

4. Disclose by whom:
This information may be disclosed by:
Name/Entity:_____
Address:_____

5. Disclosed to:
Houston Thyroid and Endocrine Specialists. 6624 Fannin, suite 2360 St. Houston, TX 77030 **ph** 713.795.0770 **fax** 713.795.0855

6. Expiration date:
State the date on which authorization expires. If the date is not provided, HTES will accept this signed form for seven (7) years from date of signature.
Research expiration date can be "none" _____/_____/_____

7. Authorization granted by: _____ _____
Name printed Date

Signature _____ ☐ self ☐ other_____ (relationship to patient)

Patient, spouse, legal representative, or beneficiary (patient's spouse may authorize disclosure of the patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan)

8. I understand the if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations

Signature:_____ **Print name:**_____ **Date**____/____/____

You are not required to sign this form as part of treatment or payment

You may refuse to sign this authorization

Patient or other party signing this authorization form has the right to receive a copy of the authorization form. The authorization may be changed or revoked, in writing, to prevent disclosure of information, except for any previous use of protected health information made in good faith under this authorization. HTES and its staff are hereby released from any legal responsibility or liability for disclosure of the above information covered under this authorization.