HARBOR HEALTH MEDICAL GROUP

Authorization to Disclose Protected Health Information

Email address:

I authorize the Harbor Health entity that maintains my records to disclose my protected health information to the following related entities, which together comprise Harbor Health's medical group operations: Harbor Health Primary Providers; South Hill Country Texas, PLLC; Harbor Health Primary Providers of West Texas, PLLC; Harbor Health Primary Providers of South Central Texas, PLLC; and Harbor Health Primary Providers, North Texas, PLLC.

This authorization applies to disclosures among these related Harbor Health medical group entities for purposes related to my treatment, care coordination, payment, health care operations, scheduling, referral management, and related administrative support.

Help us prepare for your visit! Please sign this Release of Information (ROI) form. This allows us to request your medical records in advance to help us prepare for your visit.

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Below, enter the name, address, phone and fax number for the provider or organization. The information entered below should not be your own. If you need help, just ask! We're happy to help you fill it out!

Name of Provider or Organization: *

Address, City, State, Zip Code:

Phone Number: **Fax Number:**

REASON FOR DISCLOSURE (CHOOSE ONLY ONE OPTION) *

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other (please list): _____

WHAT INFORMATION CAN BE DISCLOSED? (CHECK ALL THAT APPLY)

Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All Health Information (If checked, leave choices below blank)**

- ☐ Physician's Order
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operations Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other (please list): _____

SPECIAL SENSITIVE RECORDS AUTHORIZATION

Your consent is required to release the following information, please check the appropriate box(es).

- ☐ Mental Health Records (excluding psychotherapy notes)

- ☐ Drug, Alcohol, or Substance Abuse Records (Certain substance use records may be subject to additional federal confidentiality protections under 42 CFR Part 2)
- ☐ Genetic Information (including Genetic Test Results)
- ☐ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD

This authorization expires on the earlier of: 90 days from the date signed; completion of the records request described in this form; or the date I revoke it in writing.

Month/Day/Year:

RIGHT TO REVOKE

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION

I have read this form and agree to the uses and disclosures 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, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signing this authorization is voluntary. Harbor Health will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization, except where permitted by law.

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol, or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURES AND VERIFICATION

Printed Name of Patient | **Date**

Patient Signature

Printed Name of Consenting Adult | **Date**

Consenting Adult Signature (Parent/Legal Guardian)