

Memorial Hermann

FOR YOUR WHOLE LIFE.™

Memorial Hermann Healthcare System

Authorization for: Disclosure Inspection Amendment
Of Protected Health Information

Patient Name	Date of Birth	SS#	MR#
Address			Telephone # ()

Prohibition on Re-Disclosure of Protected Health Information Concerning Patient in Alcohol/Drug Abuse or Mental Health Treatment Program

I understand that my records are protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse or Mental Health Patient Records, 42 CFR Part 2, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. This Notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse or mental health treatment, made to you with the authorization of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize _____
Facility Name

To release information from the medical records of _____
Patient Name

To: _____
Name/Address of person/organization to which disclosure is to be made

Fax # _____ Phone # _____

For treatment dates: _____
Specify dates - this line **MUST BE** completed

For the following purpose: Medical Care Legal Insurance Other (detail below)

Select Portions

- | | |
|---|--|
| <input type="checkbox"/> Abstract/Pertinent Information | <input type="checkbox"/> Entire Record EXCLUDING - HIV Testing & Chemical Dependency. |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Entire Record INCLUDING - HIV Testing & Chemical Dependency. |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Entire Record INCLUDING - HIV Testing only. |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Entire Record INCLUDING - Chemical Dependency only. |
| <input type="checkbox"/> Nursing Notes | <input type="checkbox"/> Itemized Bill |
| <input type="checkbox"/> H & P | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardiac Studies | |
| <input type="checkbox"/> MD Progress Notes | |
| <input type="checkbox"/> MD Orders | |
| <input type="checkbox"/> Face Sheet | |
| <input type="checkbox"/> Operative/Procedure Report | |

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Memorial Hermann Healthcare System to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

Date Signature of Patient/Parent/Conservator/Guardian Authority/Relationship to

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information.
Payment is due at time of release.