□ Rolling Plains Memorial Hospital	200 East Arizona	Sweetwater, Texas 79556
□ Rolling Plains Memorial Hospital Rural Health Clinic	201 East Arizona	Sweetwater, Texas 79556
□ Rolling Plains Memorial Hospital Medical Associates	301 Jenny George Lane	Sweetwater, Texas 79556

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _________________________________ DOB: ___________________ Phone: ____________________

Patient Address: _______________________City: ____________________ State: _________ Zip code: _____________

1. I authorize Rolling Plains Memorial Hospital to make the disclosure or use the above named individual's protected health information as described below.

2. The information to be used or disclosed from dates ________________________ to _________________________is:

___ Emergency room record	___ EKG	___ X-ray
___ History and physical	___ EEG	___ CT scan
___ Discharge summary	___ Lab (Specify):	___ MRI
___ Consultation report	______________	___ Nuclear medicine
___ Operative report	______________	___ Ultrasound
___ Pathology report	______________	___ Mammogram
___ Billing records	______________	___ Other (specify):
___ Other (specify):	______________	_________________
___ Autopsy report_________	______________	_________________

3. Disclosure format: □ Paper □ Fax ____________________________ □ Email _____________________
□ Electronic □ USPS ________________________ □ Other______________________

4. ___ I understand that my medical record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental or behavioral health services, developmental disability health services, or treatment for alcohol and drug abuse. By initialing here I authorize its disclosure.

5. The above protected health information may be disclosed to and used by the following individual or organization:

Name: ____

Address: ____________________________City: ____________________ State: ______ Zip code: _______

Phone: ______________________________ Fax (health care provider only): _________________________

6. The purpose of this disclosure is for the following:

___ Continued medical care	___ Commercial insurance	___ Attorney/legal reasons
___ Personal use	___ Worker's Compensation	___ At the request of the individual

7. I understand that I have a right to revoke this authorization at any time. The revocation must be in writing, dated later than the original authorization and signed by me or my personal representative, and presented to the facility noted above. 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 if law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________. If I fail to specify an expiration event or condition, this authorization will expire in six (6) months (or 180 days).

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules.

10. If this authorization is being requested by the facility noted above for its' own uses and disclosures of a patient's protected health information, then a signed copy of the authorization will be given to the patient and the use and disclosure documented.

11. I understand that there may be a fee charged for the copying of the requested information.

____ ______________________________________

Signature of patient or personal representative — Date

____ ______________________________________

If signed by personal representative, relationship to patient — Signature of witness