



REQUEST FOR MEDICAL RECORDS FOR:

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

Patient's Name: _____
Address: _____
DOB _____ **Phone:** _____ **Account#** _____
City _____ **State** _____ **Zip** _____

I request:

Dr. _____
Clinic Name _____
Address _____
Phone _____ **Fax** _____
City _____ **State** _____ **Zip** _____

To release my records to: Ophthalmology Associates

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION

I hereby request that copies of the following records for (dates) _____ through _____
ARE RELEASED AND SENT TO:

Dr. _____
Ophthalmology Associates
1201 Summit Avenue
Fort Worth, Texas 76102

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> All Ophthalmic Imaging | <input type="checkbox"/> 1st & Last Visual Field | <input type="checkbox"/> Imaging Results |
| <input type="checkbox"/> First and last clinic note | <input type="checkbox"/> All OP Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Clinic notes last 3 months | <input type="checkbox"/> Most Recent H&P | <input type="checkbox"/> Last EKG/Cardiology Reports | |
| <input type="checkbox"/> Other _____ | | | |

Your initials are required to release the following information.

- | | |
|---|--|
| _____ Mental Health Records (excluding psychotherapy notes) | _____ Genetic Information (including Genetic Test Results) |
| _____ Drug, Alcohol, or Substance Abuse Records | _____ HIV/AIDS Test Results/Treatment |

REASON FOR DISCLOSURE (Choose only one option)

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Treatment/Continuing Medical Care | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> School | <input type="checkbox"/> Employment | <input type="checkbox"/> Other _____ | |

Please MAIL OR EMAIL records if page count is over 20 pages! CHARTROOM@OAFW2020.COM

EFFECTIVE TIME PERIOD. This authorization is valid until the earliest occurrence of one of the following: the individual reaches the age of majority, (if a minor) or until permission is withdrawn in writing; or until **1 year after date below** or until the death of the individual.

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.

 Signature of Patient or Patient's Authorized Representative

 Date

 Printed name of Patient or Patient's Authorized Representative

 Relationship

Important Information About the Authorization to Disclose Protected Health Information

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181).

Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §§ 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c) (2)(ii); psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).