

Livingston Pediatric Clinic
400 Ogletree Drive, Livingston, Texas 77351
203 N. College, Cleveland, Texas 77327
PH: 936-328-8812 or 281-592-6000 Fax: 936-328-8815

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the protected health information. Covered entities as that term is defined by HIPAA and Texas health & Safety Code 181.001 must obtain a signed authorization for the individuals 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. **Covered entities may use this form or any other form that complies with HIPAA the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Name of Patient or Individual:

Phone _____ Email(optional): _____

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

LIVINGSTON PEDIATRIC CLINIC

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: _____

Address: _____

Phone: _____ Fax: _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want to be 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** ☐ Vaccine Record ☐ Other: _____

Your initials are required to release the following information: ☐ Mental Health Records (excluding psychotherapy notes) ☐ Drug, Alcohol, or Substance Abuse Records ☐ Genetic Information (including Genetic Test Results) ☐ HIV/AIDS Test Results/Treatment

Reason for Disclosure: ☐ Changing PCP ☐ Personal Use ☐ Other _____

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: _____ Date: _____

(Signature of Individual or Individual's Legally Authorized Representative)

Printed name of legally authorized Representative (if applicable):

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Legal Guardian ☐ Other: _____

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional) 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.

Texas Medical Records Fee Amounts: All records will be provided on a CD, unless requested otherwise. For Paper copies there will be a charge of \$25.00 for the first 20 pages and \$0.50 per page for every copy thereafter. In addition, a reasonable fee may include actual cost for mailing, shipping, or delivery.

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 disease, and drug, alcohol or substance abuse, and mental health treatment (see, e.g., Tex. Fam. Code 32.00.).