

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**



\* D T O O 7 2 \*

1. I hereby authorize **JPS Health Network 1500 South Main St. Fort Worth, Texas 76104** to use and disclose protected health information from the record(s) of:

Patient's Name: \_\_\_\_\_  
Birth date: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Service: \_\_\_\_\_  
Medical Record Number: \_\_\_\_\_

2. Specifically, copies of the following records shall be used and disclosed:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Nursing	<input type="checkbox"/> EEG/EKG/CAT Scan
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Social Services Notes	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Other: Please Specify
<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Radiology	_____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check one or more, as applicable)

Used by members of JPS Health Network's work force.

Sent to:      Name of Recipient: \_\_\_\_\_  
                    Name of Company: \_\_\_\_\_  
                    Address: \_\_\_\_\_  
                    City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Faxed to:      Name of Recipient: \_\_\_\_\_  
                    Name of Company: \_\_\_\_\_  
                    Fax Number: \_\_\_\_\_  
                    Confirmation Telephone Number: \_\_\_\_\_

5. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

6. Protected Health Information is needed for: (Please check one)

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Insurance	<input type="checkbox"/> School
<input type="checkbox"/> Legal Purposes	<input type="checkbox"/> Social Security/Disability
<input type="checkbox"/> Military	<input type="checkbox"/> Other: Please Specify: _____

7. I understand that I may revoke this authorization in writing at any time except to the extent that JPS Health Network has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the **Privacy Officer, 1500 S. Main Street, Fort Worth, Texas 76104** stating my intent to revoke this authorization.

8. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is 180 days from the date of signature. I understand that JPS Health Network may not condition treatment on my completion of this authorization form.

Signature of Patient or Patient's Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name of Legal Representative (if any): \_\_\_\_\_  
Representative's Authority to Act for Patient: \_\_\_\_\_