AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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:

___ History and Physical
___ Discharge Summary
___ Operative Report
___ Physician Progress Notes
___ Nursing
___ Social Services Notes
___ Laboratory
___ Radiology
___ EEG/EKG/CAT Scan
___ Physician Orders
___ Other: Please Specify _____

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)

___ Continuing Medical Care
___ Insurance
___ Legal Purposes
___ Military
___ Personal Use
___ School
___ Social Security/Disability
___ 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: _____