Authorization of HIE

JPS Health Network
Fort Worth, Texas

Name of Patient: _____ Date of Birth: _____

Address: _____

Phone and/or Email: _____

I, the signer, agree to JPS Health Network's Health Information Exchange (HIE) to release my health records to my HIE providers.

This gives future use to records by the HIE to my providers' past and now. It starts after the date of this signed form once the form is processed.

The Data Integrity team takes up to 72 hours once the form is received.

Date: _____ Signature: _____
Patient or Legally Authorized Proxy

_____
Printed Name of Patient or Legally Authorized Proxy

_____ _____
For Departmental Use: MRN/Acct # Relation to Patient

A "legally authorized representative/proxy" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. NOTE: Written evidence of legally authorized representative status must be presented to the provider before the release of any information.

Mail, fax, or email this form to the Data Integrity team.

Address:	Attn: Health Information Management, Data Integrity 1500 S. Main Street Fort Worth, Texas 76104
Fax:	817-702-5700
Send encrypted e-mail to:	him-dataintegrity@jpshealth.org