

**HCA PHYSICIAN SERVICES
SHADOW CREEK MEDICAL ASSOCIATES**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. <i>(optional)</i> :
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Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):
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PHI Recipient Name: SHADOW CREEK MEDICAL	Address/City/State/Zip 10970 SHADOW CREEK PKWY., SUITE 350, PEARLAND, TX 77584	Phone Number: (713) 436-3697 Fax Number: (281) 997-6532
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PHI Sender Name:	Address/City/State/Zip	Phone Number: () _____ Fax Number: () _____
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This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: _____ Event: _____

Purpose of Disclosure:

Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization.

No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record		<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Demographics	
<input type="checkbox"/> History and Physical		<input type="checkbox"/> Laboratory		<input type="checkbox"/> Rehabilitation	
<input type="checkbox"/> Consult Report		<input type="checkbox"/> Imaging/Radiology		Services	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Nursing Notes		<input type="checkbox"/> Special Test/Therapy	
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Medication Record		<input type="checkbox"/> Itemized Bill/Claims	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

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Section C: Signatures	
I have read the above and authorize the disclosure of the protected health information as stated.	
Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: