Authorization for Use and Disclosure of Protected Health Information (PHI)

Section A: this section must be completed for all Authorizations

Patient Name:	Birth Date:	Social Security No. (*optional*)

Name and Address: **Muenster Memorial Hospital** **605 N. Maple** **P.O. Box 370** **Muenster, TX. 76252** **Phone 940-759-2271** **FAX 940-759-5080**	Recipient's Name and Address:

This authorization will expire in thirty (30) days unless otherwise specified: (Fill in the Date or the Event but not both.)
Date: Event:

Date of service and purpose of disclosure:

DESCRIPTION OF INFORMATION TO BE DISCLOSED

Is this request for psychotherapy notes? **If Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below**. If No, then you may select (check) as many items as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
All PHI in Record Admission Form Dictation Reports Physician Orders Intake/Outtake Clinical Test Medication Sheets		Operative Notes Therapy Notes Rhythm Strips Nursing Records Transfer Forms ER Information Special Tests		Radiology Itemized Bill UB-04 Lab Tests EKGs Portal Access 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 that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. 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 disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may request a copy of this form if desired.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

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Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? Yes No If yes, describe:	
Section C: Signatures	
I have read the above and authorize the disclosure of the protected health information as stated:	
Signature of Patient or Patient's Representative:	Date and Time:
Print Name of Witness Date and Time:	Witness Signature Date & Time: