Authorization

For the Use and Disclosure of Protected Health Information

Patient Name *(as listed in medical records)* **:** _____ **Date of Birth (mm/dd/yyyy):** _____

Date of Authorization: _____ **Email:** _____ **Phone #:** _____

Fax #: _____ **Mailing Address:** _____

City: _____ **State:** _____ **Zip:** _____

**** By completing and signing this Authorization Form, I am authorizing Athens Center for Sleep Disorders / Dr. Ronald Cates and/or their designated Medical Records/Database Custodian(s) to use and/or disclose my Protected Health Information (PHI) as detailed below :**

◯ **ALL** pertinent and applicable sleep-related records; for **ALL** dates.

◯ I authorize **ONLY** these specified records; and for **ONLY** the specified dates *(if applicable); [if not specified, ALL dates will be included]* :

- As specified: _____

State the purpose for the release of your PHI: *[Choose **only one** option below]*

- ◯ Continuation of sleep-related medical care
- ◯ Continuation of CPAP and Supplies
- ◯ Personal Use
- ◯ School or Employment
- ◯ Insurance
- ◯ Other: _____

[Selections directly below require proof that such application has been processed or is pending]

- ◯ Application for Disability or Other Benefits
- ◯ Application to "Aid to Families with Dependent Children"
- ◯ Medicaid or Medicare
- ◯ Supplemental Security Income
- ◯ Federal Old-Age and Survivors Insurance

Preferred method of receiving health information: *[Please specify or it will be sent via US mail. The use of email is not allowed]* ◯ **US Mail** ◯ **Fax**

Please specify to whom the information may be released: ◯ **Self** ◯ **Other:** *[You must complete info below]*

☐ I am requesting info be sent to ***SELF***. **- and -** ***ALL*** requested contact info is the exact same as at the top. ***Otherwise, please continue with the following:***

Person, Doctor, or DME Co: _____ ***Tele # :*** _____ ***Fax #:*** _____

Mailing Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

**** The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.**

**** CHECK ONE:** ◯ **I CONSENT... - or -** ◯ **I DO NOT CONSENT..... to the release of this type information**

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a thir d party or to take part in a research study) and that I may have the right to refuse to sign this authorization. This authorization is valid until the earlier of 180 days, at the individual's death or reaching age of majority, its withdrawal/ revocation, or an earlier specified date as listed here (specify if desired):*

I may revoke this authorization earlier and at any time by notifying the Medical Records Custodian, in writing, at 7450 CR 2800, Athens, TX 75751, of my intent to do so. However, I am aware and unde rstand that such a revocation will have NO effect on any information already used or disclosed pursuant to this authorization and preceding the record custodian's receipt of my written revocation; or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If neither federal nor Texas privacy law apply to the recipient of this information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by federal or Texas privacy law. [Please refer to Texas Health and Safety Code §181.154(c) and/or 45 C.F.R.§ 164.502(a)(1).] I may produce and retain a copy of this authorization after I have signed it.

**** By placing my signature on this form, I am hereby attesting that I am being honest and truthful about my claimed identity; and that all information supplied on this form is complete, accurate and truthful to the best of my knowledge.**

SIGNATURE: _____ **Date:** _____

◯ **I am the PATIENT** **-or-** ◯ **I am the Patient's "Legally Authorized Representative" ***

- Printed Name of "Legally Authorized Representative" * *(if Applicable)* **:** _____

- Basis for this Authority: ☐ **Parent of a Minor** ☐ **Guardian** ☐ **Other:** _____

** "Legally Authorized Representative" as used herein means any person authorized to act on behalf of another individual. (Tex. Occ. Code §151.002(6); Tex. Health & Safety Code §§166.164, 241.151; and Tex. Probate Code §3(aa)).*

For Healthcare Organization Use Only: *Date Received:* *Staff Member Processing Authorization:* _____ 12-04-19