AUSTIN REGIONAL CLINIC

Authorization for Use and Disclosure of Protected Health Information to a Spouse or Other Individual

This form authorizes Austin Regional Clinic (ARC) and its designated representatives to use and disclose your Protected Health Information ("PHI") to your spouse or other individual described below, for a purpose other than treatment, payment, or health care operations and at your request. You only need to complete this Authorization if you want ARC to disclose your PHI to your spouse or another individual to whom you authorize us to disclose your PHI. PHI is information that identifies you as an ARC patient and relates to your past, present, or future physical or mental health condition and related health services.

Your Full Name: _____

First Name Middle Name Last Name

Address: _____

Street Apt. # City State Zip Code

Date of Birth: _____ Phone # *(w/ area code)*: _____

Individuals You Authorized to Receive Your PHI from ARC

Name of Person to Receive PHI	Relationship to You	Address	Zip Code	Phone #: *(w/area code)*	Duration of Authorization

☐ I authorize ARC to release my entire medical and billing records. I understand that checking this box authorizes the use or disclosure of all information in my medical and billing record including, demographic information, diagnostic imaging reports, test results, laboratory reports, physical therapy records, physician exam results, diagnostic information, family medical history, sensitive information, including: genetic testing, mental and behavioral health (excluding psychotherapy notes), sexually transmitted diseases such as HIV/AIDS, prescription medication and history, pregnancy/maternity, and chemical dependency (including alcohol and drug treatment).

☐ I authorize ARC to release only the following information from my medical and billing records:

_____

_____

I ☐ **DO** ☐ **DO NOT** authorize this information to be disclosed electronically.

I ☐ **DO** ☐ **DO NOT** authorize immunization and annual physical information to be released to the school.

I understand that I may refuse to sign this Authorization. I also understand that information released to the person(s) authorized above may be subject to re-disclosure by the recipient and may no longer be protected by Federal and state privacy regulations.

*This Authorization shall remain effective indefinitely, unless otherwise stated above or revoked by me, except to the extent that action has been taken in reliance on this Authorization, by providing written notice to ARC addressed to the: Privacy Officer

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

Please send completed form to your doctor's clinic.

_____ _____

Signature of Individual Date