Rolling Plains Memorial Hospital
200 East Arizona
Sweetwater, Texas 79556

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient name: _____ DOB: _____

Patient Address: _____City: _____ State: _____ Zip code: _____

1. I authorize Rolling Plains Memorial Hospital to make the disclosure or use the above named individual's protected health information as described below.

2. The information to be used or disclosed from dates _____ to _____is:

| | | |
|---|---|---|
| ___ Emergency room record | ___ EKG | ___ X-ray |
| ___ History and physical | ___ EEG | ___ CT scan |
| ___ Discharge summary | ___ Lab (Specify): | ___ MRI |
| ___ Consultation report | _____ | ___ Nuclear medicine |
| ___ Operative report | _____ | ___ Ultrasound |
| ___ Pathology report | _____ | ___ Mammogram |
| ___ Billing records | _____ | ___ Other (specify): |
| ___ Other (specify): | _____ | _____ |
| ___ Autopsy report_____ | _____ | _____ |

3. ___ I understand that my medical record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychiatric services, or treatment for alcohol and drug abuse. By initialing here I authorize its use or disclosure.

4. The above protected health information may be disclosed to and used by the following individual or organization:

   Name: _____

   Address: _____City: _____ State: _____ Zip code: _____

5. The purpose of this disclosure is for the following:

| | | |
|---|---|---|
| ___ Continued medical care | ___ Commercial insurance | ___ Attorney/legal reasons |
| ___ Personal use | ___ Worker's Compensation | ___ At the request of the individual |

6. I understand that I have a right to revoke this authorization at any time. The revocation must be in writing, dated later than the original authorization and signed by me or my personal representative, and presented to the Health Information Management department of Rolling Plains Memorial Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company if law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration event or condition, this authorization will expire in six (6) months (or 180 days).

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management department or the Privacy Officer of Rolling Plains Memorial Hospital.

_____ _____
Signature of patient or personal representative Date

_____ _____
If signed by personal representative, relationship to patient Signature of witness