Authorization for Use and Disclosure of Protected Health Information

By signing this form, I request and authorize that Christopher Williams, M.D., and Sierra Ridge Family Medicine disclose certain Protected Health Information (PHI) to the entities listed below as requested on this form. By signing, I agree to pay immediately upon request any charges associated with the provision of this information. By signing, I certify that I am the person with appropriate legal rights and authority to provide this consent and will assume all liability associated with the release of this PHI.

This authorization allows the conveyance of information concerning:

Name:_____ Social Security Number (For ID Only)_____.

Date of Birth:_____

Please provide the following personally identifiable health information for the purposes noted as checked and described below:

□ *Pertinent Medical Record Information** for use in continued healthcare by a healthcare provider. (Free or Conveyance charge only required when requested prior to October 1, 2006 and provided directly by fax to a Kerr County treating entity. Otherwise, copying and conveyance charges apply)

□ *Pertinent Medical Record Information** for emergent use by a healthcare provider* (No charge required and expedited handling when confirmed and provided directly to treating entity.)

□ *Pertinent Medical Record Information** for personal use by fax, encrypted email, or on CD for computer. (Discounted significantly with lower rate per page and less page charges by eliminating old and redundant information.)

□ Medical Billing Records for personal use. (Copying and conveyance charges apply).

□ Laboratory and Radiology Reports for personal use (Copying and conveyance charges apply).

□ Other. Please specify information desired and intended use. (Copying and conveyance charges apply).

○ History and Physical. ○ Problem List ○ Medication Lists ○ Full Maintained Medical Chart

○ Progress Notes: Dates:_____ to _____.

○ Lab Results:_____ ○ X-ray Results:_____.

_____

_____.

Information should be conveyed to:

Name:_____.Secure Fax #:_____.

Address - Line 1:_____.

Address - Line 2:_____.

City, State & Zip: _____. Phone #:_____.

All applicable information should be provided on this form to facilitate release of desired health information.. When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. Requestor has the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to the Privacy Officer. Payments may be required prior to information release. Correspondence & requests should be sent to:

Sierra Ridge Family Medicine
Medical Records/ Privacy Officer
P.O. Box 859
Ingram, TX 78025
Fax (214) 722-1545

**Record information considered "Pertinent Medical Record Information" will generally include an initial history, recent progress notes, recent prescription copies, recent laboratory results, and recent consultation reports and possibly a summary of other records. Items included without charge will be determined solely by Sierra Ridge Family Medicine staff and will not be subject to appeal. Current (July 2006) allowable charges for copies of medical records in Texas are $20.00 for pages 1-20 then $0.50 per page over 20 pages.*

_____ _____

Signed By: Date

_____ _____

Print Name Relationship to Patient

Address:_____ City_____ State_____

Zip_____ Fax #:_____ eMail_____

Patient/guardian must be provided with a signed copy of this authorization form.