



AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH CONDITIONS

Please read this entire form before signing. Complete all sections that apply to your decisions regarding disclosure of protected health information.

Member's Name (Last, First and Middle):		Date of Birth:	Last Four Digits of SSN:
Member Identification Number:			
Street Address:		City:	State:
			ZIP Code:
Area Code and Phone No.:	Alternative Area Code and Phone No.:	Email Address (optional):	

I, or my authorized representative, acknowledge that Preferred Administrators has provided me a copy of this authorization and has notified me that:

1. By my request and through signing this Authorization, Preferred Administrators is authorized to release the selected protected health information or other confidential information to the person or organization listed below.
2. By signing this Authorization, State and federal law permits Preferred Administrators to disclose information about me.
3. My records (including alcohol and drug abuse information, mental status information, and human immunodeficiency virus test results) are protected by federal regulation or state law from disclosure.
4. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment, enrollment, or eligibility for benefits.
5. I understand that the information I authorize Preferred Administrators to disclose may be re-disclosed by the recipient and will no longer be protected by federal privacy regulations.
6. Preferred Administrators cannot promise that the person or organization I authorize to receive my information will not share it with someone else.
7. I understand that I have the right to revoke this authorization at any time. A valid revocation must be in writing and presented to El Paso Health. My revocation of this Authorization will not apply to information that has already been released in response to this authorization.

I authorize disclosure of protected health information and other information specific to my service plan to:

Person or Organization Name:	Area Code and Phone No.:	Area Code and Fax No.:
Street Address:	City:	State:
		ZIP Code:

Effective Time Period of Authorization

Authorization will remain valid until 1) the Death of the Member; 2) the Member reaching the age of majority; 3) permission is withdrawn; or 4) Specified date (optional): Month _____ Day _____ Year _____

Information to be Released

☐ Consultation Reports	☐ Diagnostic Test Reports	☐ Discharge Summary	☐ Operation Reports	☐ All health information
☐ EKG/Cardiology Reports	☐ History/Physical Exam	☐ Pathology Reports	☐ Physician's Orders	
☐ Radiology Reports & Images	☐ Past/Present Medications	☐ Billing Information	☐ Lab Results	☐ Other: _____

Your initials are required to release the following information:

_____ Mental Health records (excluding psychotherapy notes)

_____ Genetic Information (Including Genetic Test Results)

_____ Drug, Alcohol or Substance Abuse Records

_____ HIV/AIDS Test Results/Treatment

Reason for Disclosure

☐ Treatment/Continuing Medical Care	☐ Billing or Claims	☐ Insurance	☐ Disability Determination	☐ School
☐ Personal Use	☐ Legal Purpose	☐ Employment	☐ At the request of the Member	☐ Other: _____



Signature Authorization

I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form has no impact on prior disclosures of health information or disclosures that are otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code Section 181.154(c) or 45 Code of Federal Regulations (CFR) Section 164.502(a)(1). **If this Authorization is signed by a personal representative of the Member, a description of such representative's authority to act for the individual must be stated. If the person signing this authorization is not the Member, you must provide a copy of the medical power of attorney, guardianship, birth certificate or other relevant document that authorizes you to act on the Members' behalf, and proof of identity.**

Signature of Person or Person's Authorized Representative

Date

Printed Name of Representative

Relationship to Person

Signature of Witness *(Required if patient unable to sign and date form but gives verbal consent)*

Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code Section 32.003).

Signature of Minor Individual

Date

Revocation or Withdrawal of Authorization for Disclosure

Date of Revocation or Withdrawal:

Time of Revocation or Withdrawal:

Printed Name of Person Requesting Revocation or Withdrawal

Signature of Person Requesting Revocation or Withdrawal

Relationship to Person

Date

Signature of Witness *(if person is unable to sign)*

Date

MAIL OR DELIVER COMPLETED FORMS AND ANY SUPPORTING DOCUMENTATION TO:

ATTN: Member Services
El Paso Health
1145 Westmoreland Drive
El Paso, Texas 79925
Phone: 915-532-3778
May Be Faxed To: (915) 225-6749

Please Include Copy of Driver's License or ID