Authorization for Release / Request of Protected Health Information (PHI)

Prepayment Charge: There is a prepayment charge of $10 per patient for electronic records to be faxed and $25 per patient for records to be printed and picked up in office, in accordance with Texas Health and Safety Code §241.154.

Patient Information: _____
Name Date of Birth Phone Number

Address: _____
Street City State Zip Code

I authorize Austin Health Partners & Cedar Park Pediatric and Family Medicine to: (check one)

☐ **Release** (Transfer out) Information to: **OR** ☐ **Obtain** (Transfer in) information from:

Name of Provider/Facility or Individual Name: _____

Address: _____

City/State/Zip Code_____

Fax Number: _____

The following information is authorized to be released or obtained: (check one)

☐ All Medical related information.

☐ Medical information related ONLY to: _____

☐ Medical related information from: _____ to _____

☐ Other: _____

Reason for Disclosure (Choose only one option):

☐ Treatment/Continued Patient Care ☐ Personal Use ☐ Attorney/Legal ☐ Insurance

Signature Authorization: *I have read this form and agree to the uses and disclosures of the information as described*

_____ _____

Signature of Individual or Legal Authorized Representative: *Date*

Relationship to Individual: ☐ Self ☐ Parent of Minor ☐ Guardian ☐ Other: _____

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 § 32.003).

_____ _____

Signature of Minor *Date*

In accordance with state law and regulatory agency requirements, the health record is the property of Austin Health Partners. HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or legally authorized representative to electronically disclose that Individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law .

CPPFM Fax: (512) 336-2778 345 Cypress Creek Rd. Ste 104, Cedar Park, Tx 78613 info@cedarparkdoctors.com

Email is not a secure method of communication and confidentiality cannot be guaranteed.