Department of Medical Records
4801 Alberta Ave Ste D-17
MSC21010
El Paso, Tx 79905
915-215-4482
915-215-8614(fax)

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
EL PASO

# Authorization to Release and Disclose Patient Information

| | |
|---|---|
| **PATIENT INFORMATION**<br><br>TTUHSC El Paso MRN:_____ | PATIENT NAME:_____DATE OF BIRTH:_____<br><br>Address:_____Day Phone:_____<br><br>City:_____State:_Zip:_____ |
| **RECEIVING PARTY**<br><br>☐ **Send** the information to:<br><br>☐ **Receive** the information from: | NAME:_____<br><br>Address:_____Phone:_____<br><br>City:_____ State:_____Zip:_____ |
| **INFORMATION TO BE RELEASED**<br><br>(**What** do you want sent or **released**? Check the appropriate box.) | ☐Any and All records (complete record)<br>**Only records types checked below:**<br>☐Progress notes/clinic notes ☐ Schedule<br>☐Laboratory reports ☐Other (please specify)_____<br>☐Immunization record ☐Billing Records (dates) _____<br>☐Medication record ☐Routine Record Set (indicate the date(s) of service_____)<br>(office visits, lab, radiology, medicines, immunizations)<br>**I agree that the following information may be released/used only as indicated below:**<br>1. AIDS/HIV test results, diagnosis, treatment, and related information Yes___No_____<br>2. Drug screen results and information about drug and alcohol use and treatment Yes___No _____<br>3. Mental health information Yes___No_____<br>4. Genetic testing Yes___No____ |
| **RELEASE INSTRUCTIONS**<br>(**How** do you want the information?) | ☐Paper ☐Electronic Form (CD) |
| **PURPOSE OF RELEASE**<br><br>(Why is it needed?) | ☐Continuing Care by other health care provider<br>☐Disability ☐ School<br>☐Insurance ☐Personal review<br>☐Attorney/Legal ☐Other_____ |
| **To The Receiving Party Of This Information** | This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation. Federal rules prohibit you from further disclosure unless you have received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. |

- This authorization is voluntary and I may refuse to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.
- This Authorization may be canceled by submitting a written notice to Texas Tech University Health Sciences Center El Paso (or the releasing facility). Information may be released until my written notice of cancellation is received.
- **This Authorization expires 180 days from the date signed or on the following date or event (specify) _____**
- Additional information is in TTUHSC El Paso's Notice of Privacy Practice.
- If the healthcare services are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I must contact my employer/prospective employer.

**RELEASE FROM LIABILITY:** I release and agree to hold harmless TTUHSC El Paso Clinic (or other releasing facility) and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand TTUHSC El Paso Clinic (or the releasing facility) cannot be responsible for the use or rediscover of information to third parties.

I certify that this form has been fully explained to me, I have read it or had it read to me*, and I understand its contents.

Date _____ Print Your Name _____ Patient or Legally Authorized Signature _____

Time _____ Witness/Translator * _____ Relationship to patient _____