True Hearts and Hands Hospice
(903) 422-8100 Central
(817) 435-9390 Southwest
(903) 494-5577 FAX

AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT AUTHORIZATION

PATIENT NAME: ______________________________ **DATE OF BIRTH:** _____________ **PATIENT ID:** __________

Phone: (Home) __________________________________ **(Mobile)** ____

Address: (Street)________________________________ **(City)** ______________________ **(Zip Code)** ______________

I, the undersigned, hereby authorize (enter the name of the health care provider): ___________________________________

____

to release my medical records to (name or title of the person and/or organization), and address:

____

This disclosure is being made for the following reason(s):

☐ Continuing Care ☐At My Request ☐Litigation ☐Insurance Claim ☐ Other: __________________________

Specific information to release from my medical records *(Include dates of service in the space provided):*

☐ _______________ Entire Medical Record
☐ _______________ History and Physical
☐ _______________ Copies of Bills and/or Statement
☐ _______________ Consultation Report(s)
☐ _______________ Laboratory Report(s)
☐ ___________________ Discharge Summary
☐ ___________________ Radiology Report(s)
☐ ___________________ Operative Report(s)
☐ ___________________ Pathology Report(s)
☐ ___________________ Other: _______________

Authorization of Release of the Indicated Sensitive Records *(Patient's initials required. Mark all that apply):*

☐ _______________ Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)
☐ _______________ Chemical Dependency
☐ _______________ Other: ____________________
☐ ____________________ Psychotherapy/Mental Health
☐ ____________________ Other: ________________

I release the above-named health care provider from all legal responsibility and/or liability that may arise from the release of the medical records I specified above.
I understand that I may revoke this consent at any time by sending fax or written notice to True Health and Hands Hospice, and that the consent will automatically expire twelve (12) months from the date of my signature.

I do not authorize further release to any third party. I understand that once the medical information is released pursuant to this authorization, True Hearts and Hands Hospice, LLC cannot prevent the redisclosure of that information. Redisclosure of this information will no longer be protected under the rules of the Health Insurance Portability and Account ability Act (HIPPA).

Release of Protected Health Information regarding treatment, payment or enrollment or eligibility of benefits may not be conditioned on obtaining my authorization.

_________________________ **Patient Signature**

__________________________________ **Responsible Person or Legal Guardian Signature**

____________________________ **Printed Name/Relationship to Patient**

____ **Hearts and Hands Hospice Representative Signature**

________________________ **Date**