MEMORIAL MEDICAL CENTER OF EAST TEXAS ("MEMORIAL")

Authorization for the Use and Disclosure of Protected Health Information

1. I hereby authorize Memorial to use and disclose protected health information from the record(s) of:
   Patient's Name: ____
   Date of Birth: _______________ Social Security No.: ___________________________

2. Copies of the following records shall be used and disclosed:

   ____A. Information from patient's medical record to be released:
   ___1. Complete medical records:
   or
   ___2. Select from the following:

   ☐Discharge summary
   ☐History and Physical
   ☐Progress Notes
   ☐Psychiatric/Psychological
   ☐Outpatient Clinic Visits (Dates) ____________
   ☐Operative Report
   ☐Lab, X-rays, pathology, EKG EEG, CT Scan
   ☐Doctor's Orders
   ☐Nurse's Notes
   ☐Other:____(specify)

   ____B. Administrative and payment information, including insurance or other third party coverage, billing records, financial records, eligibility or other information related to the cost of services.

   ____C. Other: ____ (Specify)

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection, or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check one or more, as applicable)

   ____ Used by members of Memorial's workforce

   ____ Sent to: Name and Address of Recipient____

   ____

   ____ Other____ (Specify)

5. I understand that to the extent any recipient of this information, as identified above is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.
6. I understand that the purpose(s) of the requested use and disclosure is (are):
   _______At the request of the individual.
   _______ Other: ____

7. I understand that I may revoke this authorization in writing at any time except to the extent that Memorial has already relied on this authorization. I understand that I may revoke this authorization by sending a written notice to the Privacy Officer, 1201 Frank Street, Lufkin, Texas 75902, or faxing a written notice to the Privacy Officer at (936) 639-7004.

8. Unless otherwise revoked, I understand that this authorization expires twenty-four (24) months after the date it is signed.

9. I understand that Memorial may not condition treatment on my completion of this authorization form.

Signature of Patient or Patient's Legal Representative______________________________ Date: ____________

Printed Name of Legal Representative (if any) ____

Representative's Authority to Act for Patient: ____