

**214 N.Camp St. 309 Silverado St.**

**Seguin, TX 78155 Fax: (830) 379-2325 LaVernia, TX 78121**

**(830) 379-8811 (830) 779-4100**

**AUTORIZACIÓN PARA USAR O DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA**

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| **Información relativa a paciente a la que se hace la autorización**:  Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Otro nombre(s) usados: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dirección:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ciudad:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado:\_\_\_\_\_\_ Código Postal:\_\_\_\_\_\_\_  Teléfono: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Correo electrónico *(opcional*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Información relativa a proveedor de atención médica o entidad del cuidado de la salud autorizado a divulger esta información**:  Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dirección:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ciudad:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado:\_\_\_\_\_\_\_\_ Código Postal:\_\_\_\_\_\_\_  Teléfono: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Información relativa a la persona o entidad que pueda recibir y utilizar esta información**:  Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dirección:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ciudad:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado:\_\_\_\_\_\_\_\_ Código Postal:\_\_\_\_\_\_\_  Teléfono: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Información específica que se divulgará**:  □ Registros médicos a partir de (fecha) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ a (fecha) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Registro Medicos Completa, incluyendo historiales de los pacientes, las notas de oficina (excepto las notas de psicoterapia), resultados de pruebas, estudios de radiología, películas, referencias, consulta, los registros de facturación, registros de seguro, y los registros recibidos de otros proveedores de atención médica.  □ Otro: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Incluya**: **(Indique con sus iniciales)**  \_\_\_\_\_\_\_\_ Registros de drogas, alcohol o abuso de sustancias  \_\_\_\_\_\_\_\_ Registros de Salud Mental  (Excepto notas de psicoterapia)  \_\_\_\_\_\_\_\_ Información relacionado con VIH / SIDA  (Incluyendo resultados de pruebas de VIH / SIDA  **\_\_\_\_\_\_\_\_** Información Genética  (Incluyendo resultados de pruebas genéticas) | **Motivo de la divulgación de la información**:  ***(Seleccione todas las que apliquen)***  □ Tratamiento/Continuando con la atención médica  □ Uso Personal  □ Facturación o Reclamaciones  □ Seguro  □ Propósitos Legal  □ Determinación de Incapacidad  □ Escuela  □ Empleo  □ Otro *(Especificar)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**The individual signing this form agrees and acknowledges as follows:**

1. **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
2. **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: \_\_\_\_\_\_\_\_ Day: \_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_.
3. **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health

care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

1. **Special Information:** This authorization may include disclosure of information relating to DRUG, ALCOHOL and

SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

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

I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES:**

Patient/Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Legal Representative, Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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.

Signature of Minor (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Esta autorización puede ser utilizada para permitir que una entidad cubierta (según dicho término se define por la ley HIPAA y la ley de Texas es aplicable) para usar o divulgar la información protegida de la salud de un individuo. Las personas que completen este formulario deben leer el formulario en su totalidad antes de firmar y completar todas las secciones que se aplican a las decisiones relacionadas con el uso o divulgación de su información de salud protegida..*