CareNow

Clinic Stamp Here

**General Purpose Form-** *Limited Patient Authorization for Disclosure of Protected Health Information*

**Patient Name:** _____ **Date of Birth:** _____

**Age:** _____ **Clinic Location:** _____

**I authorize *CareNow* to disclose or provide my protected health information to the entity or individual identified below. I understand that in the event the facility is unable to accommodate an electronic delivery as indicated, an alternate delivery will be provided. I understand there is a level of risk associated with receiving unencrypted electronic media or email and the provider is not responsible for unauthorized access to the protected health information contained in this type of format. I also understand the facility is not responsible for any risks (e.g., virus) potentially introduced to any computer/device.**

| Release to (Please print): | |
|---|---|
| **Name:** | Southwestern University Health Center |
| **Address:** | 1001 E. University, Prothro Bldg. Suite 200 |
| **City, State & Zip:** | Georgetown, TX 78626 |
| **Phone Number:** | 512-863-1252 |
| **Fax Number:** | 512-863-1310 |
| **Email Address:** | |

| Preferred Delivery Method: | |
|---|---|
| ☐ | **Mail – Paper Copy** |
| ☐ | **Pick Up – Paper Copy** |
| ☒ | **Facsimile** |
| ☐ | **Encrypted Email** |
| ☐ | **Unencrypted Email** |
| ☐ | **Electronic Media** |

**Information to be disclosed (Check all that apply)**

**Dates of treatment:** 09/02/2020 through 09/07/2020

| | | | |
|---|---|---|---|
| | **Chart Notes/Visit Summary** | | **Itemized Bill/Receipt/HCFA – CMS 1500** |
| X | **Laboratory Results** | | **Immunizations/TB Results** |
| | **Radiology Report** | | **Drug Screen Results** |
| | **Radiology Images (CD)** | | **Worker's Compensation Correspondence** |
| | **EKG** | | **Outside Records** |
| | **Entire Medical Record** | | **Other:** |

**Purpose of disclosure – Please list the purpose of the disclosure or check patient request.**

☐ **Patient Request** ☑ **Other (please specify) :** Intake Testing

**Inclusions –** I understand the disclosure of individually identifiable health information may include information concerning communicable diseases such as HIV or AIDS testing and/or results, mental illness information (excluding psychotherapy notes), and drug/alcohol/substance abuse information.

**Expirations or termination of authorization –** I understand this authorization will expire one year from the date of your signature below, unless I specify an earlier termination. A photocopy of this authorization will be treated in the same manner as the original and that I will get a copy after it is signed. I must submit a new authorization after the expiration date to continue the authorization. I have the right to terminate this authorization at any time. I must notify the privacy manager, in writing, if I decide to terminate the authorization prior to the normal expiration date. (Please list an earlier expiration if less than one year): _____

**Right to revoke or terminate –** As stated in the Notice of Privacy Practices, I have the right to revoke or terminate this authorization, except to the extent that the provider haa taken an action in reliance to the authorization prior to your termination. You may terminate this authorization by submitting a written request addressed to CareNow Privacy Manager, P. O. Box 9101, Coppell, TX 75019.

**Redisclosure –** The provider has no control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of CareNow.

**Non Conditioning –** There is no restriction of my treatment as a condition for signing this authorization.

**Right to Copy –** I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.

**Marketing –** I understand this request for protected health information is not for marketing purposes and, in no way, involves the sale of my protected health information. The recipient will not further exchange the information for financial remuneration.

**Patient or Guardian Signature:** _____ **Date:** _____

**Relationship to Patient:** _____

**Internal Use - Released By :** _____ **Date:** _____ **Time:** _____ **AM/PM** **Acct #:**_____

Revised 8/22/18