TEXAS HEALTH CARE, P.L.L.C.

RELEASE OF PATIENT INFORMATION

I CONSENT AND AUTHORIZE THE RELEASE OF ANY NORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- ☐ MYSELF
- ☐ VOICE MAIL____
- ☐ MY SPOUSE: ____
- ☐ MY CHILD(REN): ____________________________________
- ☐ MY PARENT(S): _____________________________________
- ☐ OTHER: ____

I CONSENT AND AUTHORIZE THE RELEASE OF ANY ABNORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

- ☐ MYSELF
- ☐ VOICE MAIL____
- ☐ MY SPOUSE: ____
- ☐ MY CHILD(REN): ____________________________________
- ☐ MY PARENT(S): _____________________________________
- ☐ OTHER: ____

PRINTED NAME: ___________________________________

DATE OF BIRTH: ___________________________________

SOCIAL SECURITY #: _______________________________

SIGNATURE: ______________________________________

DATE: ____

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES PATIENT THE RIGHT TO REQUEST ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME. THIS INFORMATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- ❑ HOME TELEPHONE ___________________________
- ❑ O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- ❑ LEAVE NAME/DOCTOR WITH CALL BACK NUMBER ONLY
- ❑ WORK TELEPHONE ___________________________
- ❑ LEAVE DETAILED MESSAGE ON WORK VOICE MAIL
- ❑ LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK NUMBER ONLY
- ❑ WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
- ❑ OTHER____

____
PATIENT SIGNATURE DATE

____
PRINT NAME BIRTHDATE

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED ON TEST RESULTS, PROGRESS NOTES OR PATIENT COMMUNICATION IN QUESTION WILL BE DOCUMENTED.