Uvalde Memorial Medical Center

1195 Garner Field Road, Building B
Uvalde, Texas 78801
(830) 278-3086

Provider Approval _____
Financial Approval _____
Appt. Date/Time _____

Date _____

New Patient Application Form

Please complete all required information and return the finished form by email to New_Patient_Application@umhtx.org, by fax to (830) 278-3089, or in person at our office.

Name of Preferred Provider: _____

PATIENT DEMOGRAPHICS

Patient Name _____
Last First Middle Initial

Mailing Address _____
Mailing Address City State Zip Code

Social Security # _____ E-mail Address _____
Date of Birth _____ Race _____ Phone Number _____ ☐Cell ☐Home

Please check the boxes: ☐Male ☐Female ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer _____ Work Ph # _____
Current Primary Care Physician _____ PCP Ph # _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Number _____ Group# _____

Name of Policy Holder _____ Social Security #_____ Birth Date _____

Employer _____ Work Ph #_____ Relationship to Patient _____

Secondary Insurance _____ Policy Number _____ Group# _____

Name of Policy Holder _____ Social Security #_____Birth Date: _____

Employer _____ Work Ph # _____ Relationship to Patient _____

GUARANTOR INFORMATION

Guarantor, Spouse, Parent _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Guar. Address _____
Mailing Address City State Zip Code

PERSONAL HEALTH INFORMATION RELEASE

Any information relating to your personal health

I hereby authorize ***Uvalde County Hospital Authority*** to release personal health information on the below named individual(s) to the following:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

This will include notification or change in appointments, notifications of labs or special study results, messages to return, call to the provider or clinical staff. This also allows us to have any financial conversations with the individuals listed above.

Patient or Authorized Person's Signature _____ Date _____

INSURANCE AND FINANCIAL POLICIES

If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. If you do not, payment is expected at the time of service. Co-pay, co-insurance or deductibles are your responsibility and are due at the time of service.

INSURANCE

You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that might be owed at the time of service. If you have questions about your coverage, speak to your employer or contact your insurer directly. Please present your health insurance card or policy information at the time of service. In many cases we will be able to verify your coverage before your visit. If we are not able to verify insurance coverage, payment in full is expected before your visit. If your insurance company remits payment, you will be reimbursed.

CANCELLATION/MISSED/NO SHOW APPOINTMENTS

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 48 hours in advance of your appointment. Patients who do not give 48-hour notice will be charged a fee of $50.00

METHOD OF PAYMENT

We accept Cash, Checks, Debit, Visa, MasterCard, and Discover.

AUTHORIZATIONS

I have read the above information and agree, regardless of my insurance, to be responsible for the balance on my account. I agree to pay for all services rendered that are not covered by my insurance and to notify this office should there be any change to my insurance coverage.

CONSENT and PAYMENT: I authorize Medicare, Medicaid, and other Insurance payments to be made to **Uvalde *County Hospital Authority*** and authorize release of medical information necessary to obtain payment of insurance benefits. I understand I am financially responsible for any balance not covered by my insurance and that a copy of this signature is as valid as the original. I hereby consent to treatment, lab work, and use of prescribed medications and performance of diagnostic procedures/tests. I understand that this is given in advance of any specific diagnosis or treatment and that I have the right to refuse any service. This consent will remain in full force until revoked in writing and be continuing in nature.

CONSENT TO RECEIVE ELECTRONIC COMMUNICATION

I authorize ***Uvalde County Hospital Authority*** *to* send electronic communications such as email and text messaging to the email address and cell number I have provided which includes telehealth services as needed.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

STATEMENT OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully.

Uvalde County Hospital Authority uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of ***Uvalde County Hospital Authority.***

How *Uvalde County Hospital Authority* May Use or Disclose Your Health Information

For Treatment: ***Uvalde County Hospital Authority*** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to your actions. ***Uvalde County Hospital Authority*** may use your health information when referring you to other health care professionals and facilities.

For Payment: ***Uvalde County Hospital Authority*** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnoses, and treatment or supplies used in the course of treatment. ***Uvalde County Hospital Authority*** may use your information to contact you about account balances. ***Uvalde County Hospital Authority*** may use your information to access financial assistance programs for you that may help to defray the costs associated with your care or treatment.

For Health Care Operations: ***Uvalde County Hospital Authority*** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your cases and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law: ***Uvalde County Hospital Authority*** may use and disclose information about you as required by law. For example, ***Uvalde County Hospital Authority*** may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls: ***Uvalde County Hospital Authority*** may contact you via text, phone, or email to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification: ***Uvalde County Hospital Authority*** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: ***Uvalde County Hospital Authority*** health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to the person's involvement in your care or payment related to your care.

Business Associate: In some cases, ***Uvalde County Hospital Authority*** contracts with business associates to provide services on its behalf. An example includes arrangements with business associates to provide collection services. ***Uvalde County Hospital Authority*** may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, ***Uvalde County Hospital Authority*** *requires the business associate to safeguard your information.*

Public Health: health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Your health information may be used or disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Food and Drug Administration (FDA): ***Uvalde County Hospital Authority*** may disclose to the FDA health information relative to adverse events with respect to food, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation: Your health information may use or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other uses: Other uses and disclosures will be made only with your written authorization, and you may revoke the authorization except to the extent ***Uvalde County Hospital Authority*** has taken action in reliance on such.

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of ***Uvalde County Hospital Authority*****.** The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. ***Uvalde County Hospital Authority*** reserves the right to change the Statement of Privacy Practices at any time. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Description of Personal Representative's Authority

PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Request a restriction on certain uses and disclosures of your information; however, ***Uvalde County Hospital Authority*** is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative locations; and
- Receive an accounting of disclosures.

Obligations of *Uvalde County Hospital Authority*

Uvalde County Hospital Authority is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you make to communicate health information by alternative means or at alternative locations.

Uvalde County Hospital Authority reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

Complaints

You may complain to ***Uvalde County Hospital Authority*** and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Name of Patient or Personal Representative | Description of Personal Representative's Authority

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name	**DOB**
Sex ☐Male ☐Female **Marital Status** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor	**Date of last physical exam**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Chickenpox** ☐ **Rheumatic Fever** ☐ **Polio**		
Immunizations and dates: **Please provide a copy of immunization record.**	☐ **Tetanus**	☐ **Pneumonia**
	☐ **TB or tuberculosis**	☐ **HPV**
	☐ **Influenza**	☐ **Varicella**

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name of drug	Strength	Frequency Taken

Allergies to Medications	
Name of Drug	Reaction You Had/Reason

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician-prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ High	☐ Medium	☐ Low	
	Rank fat intake	☐ High	☐ Medium	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to “binge” drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes-pks./day	☐ Chew - #/day	☐ Pipe- #/day	☐ Cigars-#/day	
	☐ # of years	☐ Or year quit			

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Would you like to speak with your provider about your risk of HIV?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Would you like to discuss physical, sexual or mental abuse with your provider?	☐ Yes	☐ No

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies: _____ Number of live births:		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times:		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy Level
☐ Nose	☐ Bladder	☐ Ability to Sleep
☐ Throat	☐ Bowel	☐ Other Pain/Discomfort
☐ Lungs	☐ Circulation	

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name *Uvalde County Hospital Authority*

Address 1195 Garner Field Road

City Uvalde State TX Zip Code 78801

Phone (830) 278-3086 Fax (830) 278-8873

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures 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, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

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 (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____

Signature of Minor Individual **DATE**

IMPORTANT IFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, commu- nicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.