

## **Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

### **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

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### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

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### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Treat you**

- We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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<b>Help with public health and safety issues</b>	<ul style="list-style-type: none"><li>• We can share health information about you for certain situations such as:<ul style="list-style-type: none"><li>• Preventing disease</li><li>• Helping with product recalls</li><li>• Reporting adverse reactions to medications</li><li>• Reporting suspected abuse, neglect, or domestic violence</li><li>• Preventing or reducing a serious threat to anyone's health or safety</li></ul></li></ul>
<b>Do research</b>	<ul style="list-style-type: none"><li>• We can use or share your information for health research.</li></ul>
<b>Comply with the law</b>	<ul style="list-style-type: none"><li>• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.</li></ul>
<b>Respond to organ and tissue donation requests</b>	<ul style="list-style-type: none"><li>• We can share health information about you with organ procurement organizations.</li></ul>
<b>Work with a medical examiner or funeral director</b>	<ul style="list-style-type: none"><li>• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.</li></ul>
<b>Address workers' compensation, law enforcement, and other government requests</b>	<ul style="list-style-type: none"><li>• We can use or share health information about you:<ul style="list-style-type: none"><li>• For workers' compensation claims</li><li>• For law enforcement purposes or with a law enforcement official</li><li>• With health oversight agencies for activities authorized by law</li><li>• For special government functions such as military, national security, and presidential protective services</li></ul></li></ul>
<b>Respond to lawsuits and legal actions</b>	<ul style="list-style-type: none"><li>• We can share health information about you in response to a court or administrative order, or in response to a subpoena.</li></ul>

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## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of This Notice**

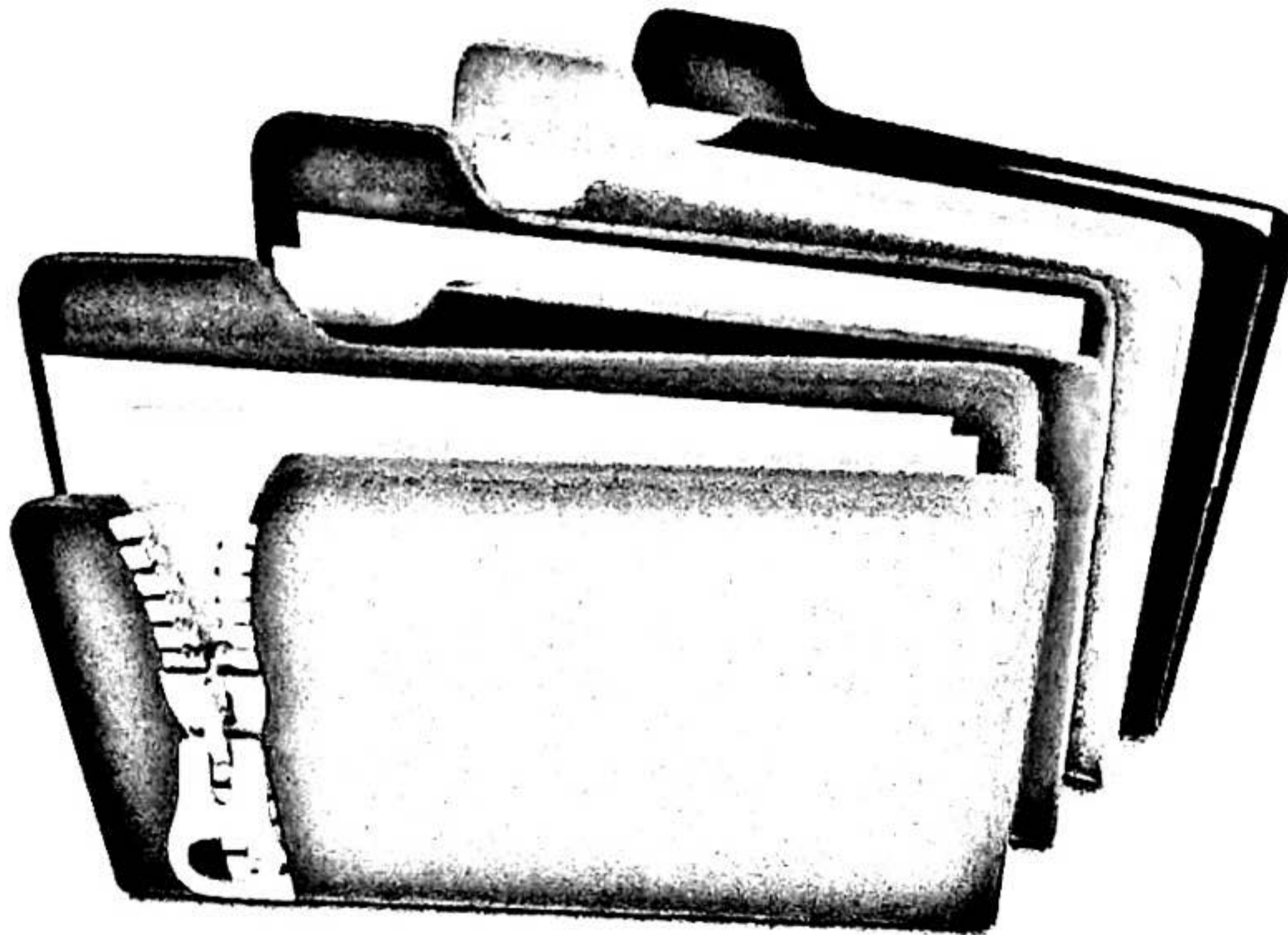
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*November 2019*

**This Notice of Privacy Practices applies to the following organizations.**

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*Martha Hughes, Office Administrator*  
*admin@drmaspons.com*  
*(915) 929-7363*



## **Su información. Sus derechos. Nuestras responsabilidades.**

Esta notificación describe cómo puede utilizarse y divulgarse su información médica, y cómo puede acceder usted a esta información. **Revísela con cuidado.**

### **Sus derechos**

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**Cuando se trata de su información médica, usted tiene ciertos derechos.** Esta sección explica sus derechos y algunas de nuestras responsabilidades para ayudarlo.

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#### **Obtener una copia en formato electrónico o en papel de su historial médico**

- Puede solicitar que le muestren o le entreguen una copia en formato electrónico o en papel de su historial médico y otra información médica que tengamos de usted. Pregúntenos cómo hacerlo.
  - Le entregaremos una copia o un resumen de su información médica, generalmente dentro de 30 días de su solicitud. Podemos cobrar un cargo razonable en base al costo.
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#### **Solicitar que corrijamos su historial médico**

- Puede solicitar que corrijamos la información médica sobre usted que piensa que es incorrecta o está incompleta. Pregúntenos cómo hacerlo.
  - Podemos decir "no" a su solicitud, pero le daremos una razón por escrito dentro de 60 días.
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#### **Solicitar comunicaciones confidenciales**

- Puede solicitar que nos comuniquemos con usted de una manera específica (por ejemplo, por teléfono particular o laboral) o que enviemos la correspondencia a una dirección diferente.
  - Le diremos "sí" a todas las solicitudes razonables.
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## Sus derechos *continuado*

### Solicitarnos que no utilicemos ni compartamos determinada información médica para el tratamiento, pago o para nuestras operaciones. No estamos obligados a aceptar su solicitud, y podemos decir "no" si esto afectara su atención.

- Si paga por un servicio o artículo de atención médica por cuenta propia en su totalidad, puede solicitarnos que no compartamos esa información con el propósito de pago o nuestras operaciones con su aseguradora médica. Diremos "sí" a menos que una ley requiera que compartamos dicha información.

### Recibir una lista de aquellos con quienes hemos compartido información

- Puede solicitar una lista (informe) de las veces que hemos compartido su información médica durante los seis años previos a la fecha de su solicitud, con quién la hemos compartido y por qué.
- Incluiremos todas las divulgaciones excepto aquellas sobre el tratamiento, pago y operaciones de atención médica, y otras divulgaciones determinadas (como cualquiera de las que usted nos haya solicitado hacer). Le proporcionaremos un informe gratis por año pero cobraremos un cargo razonable en base al costo si usted solicita otro dentro de los 12 meses.

### Obtener una copia de esta notificación de privacidad

- Puede solicitar una copia en papel de esta notificación en cualquier momento, incluso si acordó recibir la notificación de forma electrónica. Le proporcionaremos una copia en papel de inmediato.

### Elegir a alguien para que actúe en su nombre

- Si usted le ha otorgado a alguien la representación médica o si alguien es su tutor legal, aquella persona puede ejercer sus derechos y tomar decisiones sobre su información médica.
- Nos aseguraremos de que la persona tenga esta autoridad y pueda actuar en su nombre antes de tomar cualquier medida.

### Presentar una queja si considera que se violaron sus derechos

- Si considera que hemos violado sus derechos, puede presentar una queja comunicándose con nosotros por medio de la información de la página 1.
- Puede presentar una queja en la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos enviando una carta a: Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, llamando al 1-800-368-1019 o visitando [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets\\_spanish.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html), los últimos dos disponibles en español.
- No tomaremos represalias en su contra por la presentación de una queja.

## Sus opciones

Para determinada información médica, puede decirnos sus decisiones sobre qué compartimos. Si tiene una preferencia clara de cómo compartimos su información en las situaciones descritas debajo, comuníquese con nosotros. Díganos qué quiere que hagamos, y seguiremos sus instrucciones.

En estos casos, tiene tanto el derecho como la opción de pedirnos que:

- Compartamos información con su familia, amigos cercanos u otras personas involucradas en su atención.
- Compartamos información en una situación de alivio en caso de una catástrofe.
- Incluyamos su información en un directorio hospitalario.

*Si no puede decirnos su preferencia, por ejemplo, si se encuentra inconsciente, podemos seguir adelante y compartir su información si creemos que es para beneficio propio. También podemos compartir su información cuando sea necesario para reducir una amenaza grave e inminente a la salud o seguridad.*

En estos casos, nunca compartiremos su información a menos que nos entregue un permiso por escrito:

- Propósitos de mercadeo.
- Venta de su información.
- La mayoría de los casos en que se comparten notas de psicoterapia.

En el caso de recaudación de fondos:

- Podemos comunicarnos con usted por temas de recaudación, pero puede pedirnos que no lo volvamos a contactar.

## Nuestros usos y divulgaciones

Por lo general, ¿cómo utilizamos o compartimos su información médica? Por lo general, utilizamos o compartimos su información médica de las siguientes maneras.

<b>Tratamiento</b>	<ul style="list-style-type: none"><li>• Podemos utilizar su información médica y compartirla con otros profesionales que lo estén tratando.</li></ul>	<i>Ejemplo: Un médico que lo está tratando por una lesión le consulta a otro doctor sobre su estado de salud general.</i>
<b>Dirigir nuestra organización</b>	<ul style="list-style-type: none"><li>• Podemos utilizar y divulgar su información para llevar a cabo nuestra práctica, mejorar su atención y comunicarnos con usted cuando sea necesario.</li></ul>	<i>Ejemplo: Utilizamos información médica sobre usted para administrar su tratamiento y servicios.</i>
<b>Facturar por sus servicios</b>	<ul style="list-style-type: none"><li>• Podemos utilizar y compartir su información para facturar y obtener el pago de los planes de salud y otras entidades.</li></ul>	<i>Ejemplo: Entregamos información acerca de usted a su plan de seguro médico para que éste pague por sus servicios.</i>

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**¿De qué otra manera podemos utilizar o compartir su información médica?** Se nos permite o exige compartir su información de otras maneras (por lo general, de maneras que contribuyan al bien público, como la salud pública e investigaciones médicas). Tenemos que reunir muchas condiciones legales antes de poder compartir su información con dichos propósitos. Para más información, visite: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets\\_spanish.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html), disponible en español.

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**Ayudar con asuntos de salud pública y seguridad**

- Podemos compartir su información médica en determinadas situaciones, como:
    - Prevención de enfermedades.
    - Ayuda con el retiro de productos del mercado.
    - Informe de reacciones adversas a los medicamentos.
    - Informe de sospecha de abuso, negligencia o violencia doméstica.
    - Prevención o reducción de amenaza grave hacia la salud o seguridad de alguien.
- 

**Realizar investigaciones médicas**

- Podemos utilizar o compartir su información para investigación de salud.
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**Cumplir con la ley**

- Podemos compartir su información si las leyes federales o estatales lo requieren, incluyendo compartir la información con el Departamento de Salud y Servicios Humanos si éste quiere comprobar que cumplimos con la Ley de Privacidad Federal.
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**Responder a las solicitudes de donación de órganos y tejidos**

- Podemos compartir su información médica con las organizaciones de procuración de órganos.
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**Trabajar con un médico forense o director funerario**

- Podemos compartir información médica con un oficial de investigación forense, médico forense o director funerario cuando un individuo fallece.
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**Tratar la compensación de trabajadores, el cumplimiento de la ley y otras solicitudes gubernamentales**

- Podemos utilizar o compartir su información médica:
    - En reclamos de compensación de trabajadores.
    - A los fines de cumplir con la ley o con un personal de las fuerzas de seguridad.
    - Con agencias de supervisión sanitaria para las actividades autorizadas por ley.
    - En el caso de funciones gubernamentales especiales, como los servicios de protección presidencial, seguridad nacional y servicios militares
- 

**Responder a demandas y acciones legales**

- Podemos compartir su información médica en respuesta a una orden administrativa o de un tribunal o en respuesta a una citación.

## Nuestras responsabilidades

- Estamos obligados por ley a mantener la privacidad y seguridad de su información médica protegida.
- Le haremos saber de inmediato si ocurre un incumplimiento que pueda haber comprometido la privacidad o seguridad de su información.
- Debemos seguir los deberes y prácticas de privacidad descritas en esta notificación y entregarle una copia de la misma.
- No utilizaremos ni compartiremos su información de otra manera distinta a la aquí descrita, a menos que usted nos diga por escrito que podemos hacerlo. Si nos dice que podemos, puede cambiar de parecer en cualquier momento. Háganos saber por escrito si usted cambia de parecer.

Para mayor información, visite: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets\\_spanish.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html), disponible en español.

### **Cambios a los términos de esta notificación**

Podemos modificar los términos de esta notificación, y los cambios se aplicarán a toda la información que tenemos sobre usted. La nueva notificación estará disponible según se solicite, en nuestra oficina, y en nuestro sitio web.

*Noviembre 2019*

**Esta Notificación de Prácticas de Privacidad se aplica a las siguientes organizaciones.**

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*Martha Hughes, Office Administrator  
admin@drmaspons.com  
(915) 929-7363*

**Note regarding Patient Privacy Complaints:**

The government has not revealed to what exact address a patient may send a privacy complaint. For now, you may let your patients know that the Office of Civil Rights has a web site <http://www.hhs.gov/ocr/index.html> and their number in Dallas is 214-767-4056.

TMA has provided you with three versions of the Notice of Privacy Practices: Primary Care (page 23), Specialty (page 30), and Spanish (page 37). Please replace section "E" with the language provided below.

The policy entitled Patient Privacy Complaints on page 44 should also reflect this change.

**E. Complaints**

**If you are concerned that your privacy rights have been violated you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.**



# 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 \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

## REASON FOR DISCLOSURE (Choose only one option below)

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

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.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications   | <input type="checkbox"/> Lab Results            |
| <input type="checkbox"/> Physician's Orders     | <input type="checkbox"/> Patient Allergies     | <input type="checkbox"/> Operation Reports          | <input type="checkbox"/> Consultation Reports   |
| <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Diagnostic Test Reports    | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports      | <input type="checkbox"/> Billing Information   | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> 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 INFORMATION 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, communicate, 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.

## Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES before signing this consent form. I fully understand that this medical practice has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this office at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

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PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

## **Reconocimiento do Revisa de Noticia de Practicas Privadas**

Yo he revisado la Noticia de Practicas Privadas de su oficina que me explica como podra ser usada y divulgada mi informacion medica. Yo entiendo mis derechos a recibir una copia de este documento.

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Firma del Paciente o Representante Personal

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Fecha

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Nombre de Paciente o Representante Personal

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Descripcion de Autoridad de Representante Personal