OWENS-FRANKLIN HEALTH CENTER
PRAIRIE VIEW A&M UNIVERISTY
PO BOX 519 Mail Stop 1413
Prairie View, TX 77446
PHONE 936/261-1400 FAX 936 261-1452
healthservices@pvamu.edu

AUTHORIZATION TO INSPECT AND/OR RELEASE PROTECTED HEALTH INFORMATION

PATIENT'S NAME:_____ BIRTHDATE: __ __/__ __/__ __ __ __

ADDRESS:_____ _____
Street Number Street Name

_____ _____ _____ (___)_____
City State Zip Code Telephone No.

I hereby authorize Owens-Franklin Health Center to:

☐ Disclose/release the specified health information:

TO: _____
_____
_____
_____
Telephone No._____
Fax No._____

☐ Receive the specified health information

FROM:_____
_____
_____
_____
Telephone No._____
Fax No._____

The following Protected Health Information to be disclosed is maintained in the designated record set (specify the exact information to be disclosed, including dates of service):
Date(s) of Service:_____

- ☐ Complete medical record
  (OR the records marked below)
  - ☐ History & Physical Exam
  - ☐ Laboratory Test
  - ☐ Physician Orders
  - ☐ Drug/Alcohol Information
  - ☐ Consultation Reports
  - ☐ Radiology Reports
  - ☐ Report of Procedure
  - ☐ Mental Health Information
  - ☐ Progress Notes
  - ☐ Radiology Films
  - ☐ HIV Test Results
  - ☐ AIDS Information
- ☐ Billing Records
- ☐ Other (specify)_____

I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment for drug or alcohol abuse; mental or behavioral health, excluding psychotherapy notes.

I understand that Owens-Franklin Health Center may charge a fee for the cost associated with processing this request.

Owens-Franklin Health Center may deny this request to inspect and copy health information in certain limited circumstances, which are described in separate policies. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional chosen by OFHC will review your request and the denial. The person conducting the review will not be the person who denies the request. OFHC will comply with the outcome of the review.

This authorization is given freely with the understanding that:

1. I may revoke this authorization at any time, except where information has already been released.
2. The revocation must be in writing and a form is available from the medical record department.
3. This authorization will expire 180 days from the date of signature unless otherwise specified; expires_____.
4. OFHC may not condition treatment or payment upon obtaining this authorization.
5. A photocopy or fax of this authorization is a valid as the original.
6. If the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal laws. If so, federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient **for patient records applicable under federal law 42 CFR Part 2.**

_____
Signature of Patient

_____
Signature of Patient's Representative

_____
Date

_____
Representative's Printed Name

_____
Relationship to Patient

_____
Date

Owens-Franklin Health Center's Use Only:

Date Authorization Received:___ ___/___ ___/___ ___ ___ ___ Request denied: ☐ No ☐ Yes (If yes, proceed to Denial Section)

Date information released: ___ ___/___ ___/___ ___ ___ ___ _____ _____

Name of OFHC Staff processing request Title

Within 24hrs of processing request, attach form to patient's chart.

Chart#_____ Fee Assessed $_____

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DENIAL SECTION (for use only if Request Denied)

Reason for denial_____

Denial of request communicated to patient or patient representative on {date} ___ ___/___ ___/___ ___ ___ ___.

By (name & title of OFHC staff)_____