Ned Snyder IV, M.D., Renee R. Snyder, M.D., Jennifer Aranda, M.D., Robert Whitfield, M.D.,
1510 W. 34th Street Suite 100 Austin, Texas 78703
P: 512.533.9900 F: 512.533.9901

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

I understand _____ (list your provider) is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

1. Description of the information to be used or disclosed (check as appropriate):

a. ☐ My entire record:

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information.

(NOTE: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

b. My demographic information (check "All" or those that apply):

□All □Age □Gender/Race □Other_____
□Name □Address □State/Zip Code Only □Telephone

c. Medical Data/Information as related to (check all that apply):

□Specific condition(s): _____
□Specific professional service(s): _____
□Specific medication(s): _____
□Alcohol and Drug Abuse Treatment: _____
□Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment: _____
□HIV/Acquired Immune Deficiency Syndrome (AIDS): _____
□Genetic Information including, but not limited to, Genetic Test Results:
_____

2. I authorize information disclosure to be sent via:

☐ Electronically (flash drive) ☐ Mail (Paper Copy)

3. Please disclose the above information to:

Name/Entity: _____

Telephone: _____

Fax: _____

Address: _____

4. Purpose(s) for disclosure of the information:

_____

_____

(NOTE: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

5. Right to revocation.

I have a right to revoke this authorization in writing (or orally in the case of Part 2 alcohol and drug abuse services), except to the extent that action has been taken in reliance on this authorization. Your provider must receive the revocation in writing (except for Part 2 alcohol and drug abuse services) and the written revocation must include:

a. My name and address,
b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c. My desire to revoke this authorization, and
d. The date of the revocation, and my signature.

6. This authorization shall expire one year after original authorization.

After this date/event, your provider can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

7. I fully understand and accept the terms of this authorization.

_____ _____

Signature of Patient/Patient's Representative **Date**

_____ _____

Name of Patient or Representative **Description of Representative**