GRUENE LAKE MEDICAL PATIENT INFORMATION

PATIENTS LAST NAME:	FIRST:	MIDDLE:
Gender M/F	SSN:	DOB:
MARITAL STATUS: Married Single Divorced Widowed		
Race:	Ethnic Group: Hispanic/Latino OR Non-Hispanic/Latino	
ADDRESS:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Office Phone:
Email:	Preferred Contact: Email Text Phone Other:	
Who can we call in case of emergency:		Primary Phone#:
Relationship to Patient:		

Acknowledgement of Review of Notice of Privacy Practices: I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

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

Authorization to release ANY information to extended family and/or spouse and children:
Please think about anyone who may be calling for information or for billing purposes. Without their name appearing on this form, we will NOT be authorized to release ANY information.

I authorize _____to receive private medical information on my behalf regarding my medical care, billing details or arrangements.

Authorized Signature_____ Date_____

Insurance Company:	ID#:
Group#:	Phone:
Claims mailing address:	
Primary Insured Name:	DOB:
Relationship to Patient:	SS#:
Do you have secondary insurance? Yes\No	If so, please list carrier
PLEASE NOTIFY STAFF OF ANY CHANGES or OTHER INSURANCE YOU MAY HAVE!	

It is not viable to completely and accurately estimate the total cost of your encounters. Any estimate that is given by this office is based upon your benefits on the date in which they were acquired and are subject to change. It is ultimately your responsibility to know your benefits. _____Patients/Patient Rep Initials

GRUENE LAKE MEDICAL – DISCLOSURE AND CONSENT

948 Gruene Rd., Ste.140 Phone: 830-627-2700
New Braunfels, TX 78130 Fax: 830-627-2701

Medical and Therapeutic Procedures

To the patients: You have the right, as a patient, to be informed about your condition and the recommended therapies to be used so that you may make the decision whether or not to undergo the treatment after knowing the risks and hazards involved.

INITIALS _____ **Consent to Treat:** I understand that as a patient I have the right to make all decision regarding my care. I voluntarily request Anna Boecker, M.D., P.A. as my treating physician, and such associates, Physical Assistant/Nurse Practitioner, RN/LVN, technical assistants and other health care providers as deemed necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cure. I understand that my Physician and/or Physician Assistant may discover other or different conditions which require additional or different procedures than those planned. I authorize my Physician and or Physician Assistant to perform such other procedures which are advisable in their professional judgement. Specific Surgical/Diagnostic Procedures_____

INITIALS _____ **Risk and Emergency:** Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards to the treatment. I understand my risk and also **(DO/DO NOT)** consent to the use of blood, blood products, anesthesia, in cases of emergency.

INITIALS _____ **Authorization to Release Information:** I authorize Anna Boecker M.D, P.A. to release any and all healthcare information as necessary to (a) obtain payment from my payers for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment or prognosis; it will also include where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV or the diagnosis or AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, that my blood may be tested for the HIV antibody and other communicable diseases.

INITIALS _____ **Financial Authorizations:** I authorize all payers to pay directly Anna Boecker, M.D, P.A for services provided. I assign Anna Boecker, M.D., P.A. my right to receive payment from third party payers. Third party payers include anyone from whom benefits are, or may become payable to me for services provided.

INITIALS _____ **Receipt of Information:** I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients' Rights, Responsibilities and Healthcare Choices" from Anna Boecker, M.D., P.A. I certify this has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

INITIALS _____ **Financial Responsibilities:** I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I agree to pay these charges including payment no paid by my insurance company payers within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all request of my insurance company within a timely manner to ensure payment is made within 120 days.

INITIALS _____ **Property:** I understand that Anna Boecker, M.D, P.A, does not assume responsibility for any personal property.

INITIALS _____ **No Show/Late Appointment Policy:** I understand that 24 hours' notice is required for appointment cancelations and that cancellations can and must be left on voicemail if after hours. Without 24 hours' notice, I understand that fee's up to $25 may be assessed and collected prior to the next scheduled appointment or before services are rendered. After 3 no shows on records, we reserve the right to conclude our relationship for noncompliance of stated office policy. If you are more than 15 minutes late for your scheduled appointment, you will need to reschedule your appointment. The practice runs on a tight schedule in order to provide the best care for all in a timely manner.

INITIALS _____ **Vaccines:** I authorize Anna Boecker, M.D., P.A., to administer vaccines for my child as recommended by the State Health Dept. in accordance with the recommended time frame outlines by the Health Department. This authorization covers and allows for vaccines to be administers when any member of extended family brings my child for well child exams. Extended family includes_____
_____

INITIALS _____ **Sunshine ACT Disclosure:** In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally received food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufactures in conjunction with product education. We do not receive direct financial compensation from any of our vendors. By initialing here, you acknowledge this disclosure.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents.

Signature:	Date and Time:
Witness Signature:	
Name:	Relationship:

GRUENE LAKE MEDICAL

ADULT HEALTH HISTORY

Patient's Name:	Date of Birth:	Age:
Previous Doctor/Primary Care Provider:		

Present Health Concerns:	Today's Date
Allergies:	
Medications currently taking:	

SOCIAL HISTORY Single Married Divorced Widowed
Employment:
Children ○YES ○NO If Yes How Many:
Use of Alcohol ○ Never ○ Rarely ○ Moderately ○ Daily Type:
Use of Tobacco ○ Never ○ Rarely ○ Moderately ○ Daily Type:
Use of Drugs ○ Never ○ Rarely ○ Moderately ○ Daily Type:

PAST MEDICAL HISTORY- Please identify any major medical problems and list		
the date of onset & any treating providers/specialist (ex:GI Dr, Cardiologist, etc)		
Diabetes	Onset Date:	Dr:
Hypertension	Onset Date:	Dr:
Cancer	Onset Date:	Dr:
If Cancer What Type		
Stroke	Onset Date:	Dr:
Heart Disease	Onset Date:	Dr:
Thyroid Problems	Onset Date:	Dr:
Cholesterol Problems	Onset Date:	Dr:
Depression/Anxiety	Onset Date:	Dr:
Any Medical Issues not listed		
Please list any hospitalizations, surgeries, or serious injuries and dates:		

FAMILY HISTORY

Please check any box that relates to any family history of the following medical conditions:

Condition	Mom	Dad	Child	Sibling	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative(Specify)
Anemia									
Autoimmune Disorder									
Bleeding Problems									
Cancers (specify type)									
Congential anomaly/Birth Defect									
Heart Attack/Disease									
Depression									
Diabetes									
Genetic Disorder									
High Cholesterol									
High Blood Pressure									
Kidney Disease									
Stroke									
Thyroid Disorder									
Death Before Age 56 for reason not listed above (specify)									
Other									

Prescription Policy and Medication Guidelines

Goal: At Gruene Lake Medical, we are dedicated to providing your family with the best medical care available. In order to do that, we will need your assistance with requesting prescriptions to ensure they are filled properly and in a timely manner. We get many calls for last minute "urgent refills" for one reason or another. These cannot always be filled. It is the patients responsibility to comply with the below prescription policies. Our overall policy is "***one standard one rule***". Please do not ask to be our exception.

Our office does not call in antibiotics. Nor do we call in medication for a patient we have not seen.

The first step in Refills: Call your pharmacy and request a refill. A patient must be seen prior to any new prescriptions.

Process: In order for a refill to be processed, an office staff member will need to verify the prescription, and that the refill is due. The provider may also need to speak to you or see you to verify the prescription is working. For some medications, 90 day follow ups are required as proper prescription monitoring protocol. No exceptions. These guidelines are regulated by the Drug Enforcement Association and the Department of Public Safety. It is not our office policy to violate these guidelines. Many prescriptions require monitoring of body functions such as but not limited to labs, blood pressure, and vitals for your own safety.

Timeline: Prescriptions take 24-48 hours to be processed and refilled and may take up to 72 hours to process a triplicate prescription. Please allow 2-3 days to get your medications filled. This will mean calling the pharmacy before you are on the last few doses of your medication. Plan ahead if the prescription refill is due on a weekend or holiday in order to give our office enough time to research and prepare the prescription. Request for same day or walk-in refills will not be honored. This policy is laid out in order to avoid any disappointing experiences with your care in our office. A rushed refill leaves room for error and mistakes we are not willing to make.

Staff Treatment: Harassing and/or any unprofessional behavior toward our staff will not be tolerated.

After Hours: There will be no refills after hours, on the weekend, or on holidays by the on call provider. The on-call provider is for emergencies only. Non-emergency use of the on-call provider may result in a charge or fee.

Allergic Reactions: If you think you are having an allergic reaction to any medication, please call our office and/or proceed immediately to the nearest emergency room. Some medication allergies can be very serious and need immediate attention.

Medication Changes: Any changes or adjustments to your medication treatment plan such as increasing or decreasing your dosage will not be made over the phone; an appointment is required, and any changes will be noted in your chart. Prescriptions will not be changed without the patient returning the rest of the original prescription to the office for identification, counting, and disposal.

Early Refills/Lost Medications: If your prescription runs out early for any reason (for example you take more than is prescribed or you lose your medication), Gruene Lake Medical will not prescribe extra medication for you or give you an early refill. If you run out early, you will have to wait until the next prescriptions due.

Triplicate (ADD/ADHD): Patient, Parents, or an approved proxy representative must pick up the prescription, show identification and sign a log book. Triplicate prescriptions expire **21** days from the time they are written. An office visit may be required before a refill will be honored. In the event that a triplicate prescription must be rewritten for any reason, a $25 fee will be collected when the new prescription is picked up and the out dated one is returned. No expired triplicate prescriptions will be honored unless the expiring triplicate is returned. An attempt to obtain additional medication by another provider can be considered attempting to abuse narcotic prescriptions and may be referred to legal authorities. For lost or stolen triplicate medication, a police report will be required.

Controlled Substances: Controlled substances can interfere with driving, operating machinery, and overall judgment. There is to be no alcohol use while on a controlled substance. A patient should fully understand the risks of performing these actions while on the medication and will not drive or operate machinery while taking a controlled substance. Prolonged use or use beyond the recommended dosage can also lead to addiction and cause the medication to become less effective. Controlled substances can adversely affect babies, infants, and a pregnant woman's fetus. Please notify your healthcare provider if you are pregnant or plan on becoming pregnant. Keep all medications in a safe place away from children. By signing below, you acknowledge this policy and agree not to give any of your controlled substances to anyone else and to fill your prescription through only one (1) pharmacy. You also understand and agree that random urine drug screens can be ordered by your physician and if you decline this, it could result in termination from the practice and/or no further refills.

I have read the above policy and I am aware of the necessary steps and timelines for prescription. I understand my level of personal responsibility in regulating and watching my medications. I further understand that Gruene Lake Medical has not only the right to not refill my medications, but also to terminate the physician-patient relationships.

Sign: _____ **Date: _____**

Patient Name:_____

GRUENE LAKE MEDICAL PHYSICAL EXAM INFORMATION

Physical Exams: Typically, a physical exam is an annual checkup your physician uses to assess your overall health. Your physical exam benefits will cover this checkup usually without copay. **PLEASE NOTE, IF YOU SEE YOUR PCP FOR CARE OTHER THAN A WELL-EXAM (FOR EXAMPLE – AN ILLNESS OR INJURY SUCH AS THE FLU, COLD, SPRAINED ANKLE, MEDICATION CHANGES, OR ACNE) THAT VISIT IS CONSIDERED A STANDARD PHYSICIAN'S OFFICE VISIT FOR WHICH A CO-PAY AND/OR OTHER APPLICABLE BENEFITS SUCH AS A DEDUCTIBLE OR CO-INSURANCE WILL BE APPLIED BY YOUR INSURANCE.**

One type of Physical Exam is the Well-Woman visit. At a well-woman visit, the patient sees her PCP for an annual checkup with or without an annual pelvic exam. Please note that if you have your pelvic exam done with an OB/GYN, your insurance may not cover a physical with another provider. The collection of a specimen for Pap smear screening and a clinical breast exam are regular, important and recommended preventative service for women and is usually covered once per calendar year.

Another type of Physical Exam is the Well –Child visit. At a well-child visit, a pediatrician or primary care provider (PCP) performs a physical exam, hearing and vision screening, developmental/behavioral assessment, preventative guidance, lab tests, and administers immunizations for your child. Most plans today are not subject to plan deductibles and a copayment is not applied. It is the responsibility of the patient or guarantor to know and understand the plan benefits related to not only the well-child visit, but also to the administration of vaccines. This preventative care benefit is usually provided for children through age 21 at certain intervals if your plan is covered under the Affordable Care Act (ACA). If your plan has not implemented the ACA, your child may be covered for well-child visits until age 6.

During the well-child visits, your child's PCP will recommend immunizations and other related services that are based on the guidelines established by the American Academy of Pediatrics. These additional services, other than immunizations, may require a copayment or be subject to additional benefit limits. The recommendations are standard practice for our office to achieve our level of standard care provided, as we feel they are of benefit to the patients and are useful diagnostic tools in treating pediatric patients.

Annual Physical Examinations are the foundation for wellness, health promotion, and disease identification and management throughout your life. It is no secret that health living and early detection of disease increases not only your length of life, but more importantly your quality of living. A periodic annual exam for all ages is not just about good medical care, but it also gives you the opportunity to learn more about beneficial health habits, counseling and community support services, as well as an overall view of the best way to take care of yourself and your family for a lifetime.

The annual physical exam basically is performed in four parts:

- The health history is complete and includes family medical history, past medical and surgical history, current medications, social history, habits, and allergies. If you are establishing care with a new healthcare professional, your first visit may be longer and more involved than later office visits. Since your healthcare provider is not familiar with you, a detailed medical, family, obstetric, gynecologic, genetic and psychosocial history is done to develop a complete plan of care. It is important to know your family medical and genetic history. It always is a good idea to bring any medical records and a list of medications that you are already taking, including alternative treatments such as herbal preparations to your first health visit. This is a good opportunity to discuss any concerns that you may not feel comfortable talking about with family or friends such as an infection, drug and alcohol use, depression, and domestic violence. Any health information you reveal is kept confidential by law. So, be sure to ask your healthcare provider about any concerns.
- The review of body systems is performed, as well as an assessment for other potential future health problems.
- A physical includes taking your vitals and a comprehensive exam that may give clues to any health problems. Urine testing and lab work may be ordered depending on the needs of the individual patient. Your healthcare provider likely will examine eyes, ears, nose, mouth, thyroid gland, lungs, lymph nodes, heart, breasts, abdomen, reflexes, skin, bones, and spine. Any problems that are noted may results in a referral to another healthcare provider. Eye and dental care is a must for overall health too, and you should seek routine care for these health issues.
- Creation of a plan or recommendations, counseling on a variety of related areas, and possible referral for future preventive care is administered, as recommended by standard of care measures.

I have read and fully understand what this office considers a well exam. I also understand other services provided outside this scope of the well exam, which are done to achieve a high standard of care and/or to avoid another visit to the office; may be subject to a copay, deductible, and/or co-insurance.

Patient Name: Signature:

GRUENE LAKE MEDICAL PATIENT PORTAL USER AGREEMENT

Gruene Lake Medical is pleased to provide a Patient Portal in partnership with e-MD's for the exclusive use of patients in our practice. The portal is designed to enhance communication.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately, and agree to provide factual and correct information.

The Portal is **NOT** intended to provide internet based diagnostic medical services, and limitations apply:

- No internet based triage and treatment requests. Diagnosis can only be made and treatments rendered after the patient is SEEN by a medical provider in our office.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or calling 911 should the emergency be life threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 72 hours to receive a response to an email/portal request. If you do not receive a response within 72 hours you should contact the office at (830)627-2700.
- If you lose your password or username, you may request a new one through the web portal.
- Always remember to log out and close your browser when you are finished accessing the portal. **YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.**

This patient portal is provided as a courtesy to our patients. While some offices charge for the convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of the patient portal persists, we reserve the right, at our discretion, to terminate the patient portal offering, suspend user access and modify services available through the patient portal.

The patient portal is provided in partnership with e-MD's, our EHR software vendor and provider. That data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. All patients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the patient portal user agreement and have provided our office with a legitimate email address that is secure, you will be give our system generated unique user identification and password. The site may be accessed by going to http://gruenelakemedical.com/

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the patient portal and agree that I understand the risks associated with online communications between Gruene Lake Medical and myself, and consent to the conditions outlines herein. Acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Gruene Lake Medical may impose for online communications. I have been given an opportunity to ask question related to this agreement and all of my questions have been answered to my satisfaction. I also understand this consent is valid for one year.

Patient/Guardian Signature	Date
Secure/Private Patient/Guardian Email:	

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Authorization to release ANY information to extended family and/or spouse and children

Please think about anyone who may be calling in for information or for billing purposes. Without their name appearing on this form, we will NOT be authorized to release ANY information.

I authorize _____
_____to receive
private medical information on my behalf regarding my care and billing details or arrangements.

Authorizing Signature _____ **Date:** _____

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.

- ☐ **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 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.