# Use or Disclosure Authorization

Patient Name _____

Complete Address _____

Date(s) of Service _____

Date of Birth _____ SS# _____

Home Phone Number _____

I, _____, hereby authorize TOPS Surgical Specialty Hospital to use or disclose the following protected health information:

- ☐ Abstract (to include H&P, operative report, pathology report [if applicable], anesthesia record, laboratory results, and discharge summary [if applicable])
- ☐ Entire medical record
- ☐ Back-to-school/work slip
- ☐ Other (please specify) _____

The protected health information may be disclosed to:

***(Please provide the name of the person(s) or entities to whom the protected health information may be disclosed.)***

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The protected health information is being used or disclosed for the following purposes:

***(If the disclosure is at the patient's request and the patient does not choose to provide an explanation, the patient may indicate "At the patient's request." Otherwise, please provide the specific purpose(s) for the disclosure.)***

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This authorization will become invalid 180 days from the date of signature unless revoked earlier. A copy or facsimile of this authorization is as valid as the original.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I acknowledge and hereby consent to such, knowing that the released information might contain test results and other health information on HIV and AIDS. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records or indications of such and that redisclosure of this information to a party other than the one designated above is forbidden without my additional written authorization. The disclosing facility is released and discharged of any liability, and the undersigned will hold the facility harmless, for complying with this Use or Disclosure Authorization.

I understand that, as set forth in the Provider's Privacy Notice, I have the right to revoke this authorization at any time by sending written notification to:

TOPS Surgical Specialty Hospital
17080 Red Oak Dr.
Houston, TX 77090
Attn: Privacy Officer

I understand that a revocation is not effective to the extent that the Provider has taken action or relied on the authorization that is being revoked.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that: ***(Check one of the following)***

- ☐ The Provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- ☐ The health care services rendered by the Provider are solely for the purpose of creating protected health information to be disclosed to the person or entity named for disclosure above, and my authorization is a condition of this treatment. I understand that if I do not sign this authorization, the Provider will not render health care services to me.
- ☐ The treatment rendered by the Provider is related to research, and my authorization of disclosures for related research purposes is a condition of this treatment. I understand that if I do not sign this authorization, the Provider will not render research-related treatment to me.

I understand that, as set forth in the Provider's Privacy Notice, I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law, to the extent the state law provides greater access rights).

I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Personal Representative's Relationship to Patient