TEXAS A&M PHYSICIANS
TEXAS A&M HEALTH SCIENCE CENTER
transformingHEALTH™

Psychiatry & Behavioral Health
2900 E. 29th Street, Suite 101
Bryan, TX 77802
Telephone: 979.774.8200
Fax: 979.776.6905

HIPAA: Patient Release of Personal Health Records

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

1. **Please release the requested information:**

☐ TO: _____
Address: _____
Phone: _____
Fax: _____

☐ FROM: _____
Address:_____
Phone: _____
Fax:_____

I authorize this information to be disclosed in the following ways:
❑ Written/Photocopy/Paper ❑ Verbal ❑ Fax ❑ Electronic Mail *

2. **Reason for Release**: _____

4. **Dates of Treatment: All: _____** From: _____ To: _____

5. **Specific reports to be disclosed**:
- ❑ Visit Notes
- ❑ Health Summary
- ❑ Appointment History
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Photographs/Videotapes
- ❑ Discharge Summary
- ❑ Operative Reports
- ❑ Consultation Reports
- ❑ Immunization Record
- ❑ X-ray films or other images
- ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, and other referral documents.)
- ❑ Other(Specify):_____

6. **I give specific authorization to disclose the following information**:
- ❑ **HIV test results**
- ❑ **Drug and alcohol abuse treatment records**
- ❑ **Documentation of AIDS diagnosis**
- ❑ **Psychiatric/Mental Health treatment records**

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Texas A&M Health Science Center in writing.
My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.
Unless revoked earlier, this authorization expires in one year unless I specify another time: _____
I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient (or Patient Representative) Authority of Representative to Act for Patient

Identification verified by: _____ (circle type) DL—SS—Legal Document—Picture ID—(other)_____

To the party receiving this information: Information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits from making any further disclosure of it without specific written consent of the person to who it pertains, other information is not sufficient for this purpose. For Patient Records Applicable Under Federal Law 42 CFR Part 2.

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Insurance Advanced Beneficiary Notice

Patient Name: _____

Insurance Provider: _____ **Policy #:**_____

The fact that your insurance plan **may not pay** for a particular service does not mean that you should not receive it. There may be a good reason your physician recommended it. We expect that your insurance plan **may not pay** for _____for date of service _____.
Your cost may be: $_____.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you may have to pay for them yourself.

- Before you make a decision about your options, **you should read this entire notice carefully** so you can make an informed decision about your options.
- Ask us to explain if you do not understand why your insurance will not pay for this type of service.
- Choose an option below about whether to receive the services listed above.

OPTIONS: Check only one box. (We cannot choose a box for you.)

☐ **Option 1.** I want the service(s) listed above. You (the provider) may ask me to pay you now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for any remaining balance. If my insurance company does pay for the services, you will refund any payments I made to you, less co-payments or deductibles.

☐ **Option 2.** I want the services listed above, but **do not** bill my insurance plan. You may ask me to pay you now as I am responsible for the payment.

☐ **Option 3.** I do not want the services listed above. I understand with this choice I am not responsible for payment.

This notice gives our opinion, not an official insurance plan/coverage decision. If you have other questions on this notice or your insurance plan's billing, please call the number provided on your insurance identification card.

By signing below it means you have received and understand this notice. You may request a copy for your personal records.

_____ _____
Signature Date