Today's Date:	PCP:

PATIENT INFORMATION

Last name: First:	Middle Initial:	Marital Status: Single / Married / Divorced / widowed

Is this your legal name? [ ] Yes [ ] No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:

Address:

Social Security no.:	Home phone no.:	Cell phone no: Email address:
Occupation:	Employer:	How did you hear about us?
Race:	Ethnicity:	Preferred Language: English / Spanish / Other: ______________________________

Preferred Pharmacy:	(name)	(address)	(phone number)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	[ ] Yes [ ] No	Is this patient covered by insurance?	[ ] Yes [ ] No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: Self / Spouse / Child / Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Thomas Hong, D.O. PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

Patient Name: ____ Date of Birth: ________________________

Statement of Patient Financial Responsibility

Pain & Spine Specialists appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Assignment of Benefits

I have read the above policy regarding my financial responsibility to Pain & Spine Specialists, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pain & Spine Specialists, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

I hereby authorize Pain & Spine Specialists, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures. I further authorize Pain & Spine Specialists, to release to appropriate agencies, any information acquired in the course of my or the above-named patient’s examination and treatment.

Medicare Patients Release of Information

I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made directly to this physician and/or medical group and I understand that I am responsible for the remaining balance not covered by other insurance.

Notice of Privacy Practice – HIPAA Compliance

This facility is HIPAA compliant. The patient’s privacy is protected including medical and personal information. As required by law, we will use and disclose our patient’s health information in a limited way according to the requirements by all applicable laws, I, the undersigned patient, agent for patient, or legal guardian, have been informed of my privacy rights.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. Pain & Spine Specialists will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described.

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Pain & Spine Specialists. I agree to pay Pain & Spine Specialists, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient Signature ______________________________________ Date ____________________________

Patient Consent for Methods of Communication

I, ________________________________ , give my informed consent to the office Thomas J. Hong, D.O. PLLC to contact me regarding my health care, appointments, insurance and billing issues, and other important information through:

Text message
Voicemail
Email

At any point in time I may revoke my consent to communication through any of the methods previously stated by informing the office with written notice.

Patient Signature: ________________________________ Date: ___________________

Advance Beneficiary Notice

Fees for services not covered by Medicare and other Insurances

The following services are not covered by Medicare and other Insurance plans. Fees are as follows:

Printed Medical Records	$25 for the first 25 pages, then $0.25/page after
Disabled parking permit forms	$50
Family and Medical Leave Act forms (FMLA)	$150
Disability forms	$150
Other forms	$50

We ask that you cancel or reschedule your appointments 24 hours prior to your scheduled appointment date. Procedures need to be cancelled or rescheduled 48 hours prior to the date scheduled.

New patient no call/ no show	$75
Follow-up patient no call/ no show	$50
Procedure no call/ no show	$150

Patient Signature: ________________________________ Date: ___________________

PAIN MANAGEMENT COMPREHENSIVE HISTORY AND PHYSICAL

Please take a few minutes to complete this worksheet. This information will help us in providing your care.

PATIENT INFORMATION

Name:____Date: _________________________________

Address: ____

Phone Number:_________________________________Referring Physician___________________________________

Date of Birth:_______/______/______Sex:________Height:____________________Weight: ____________________

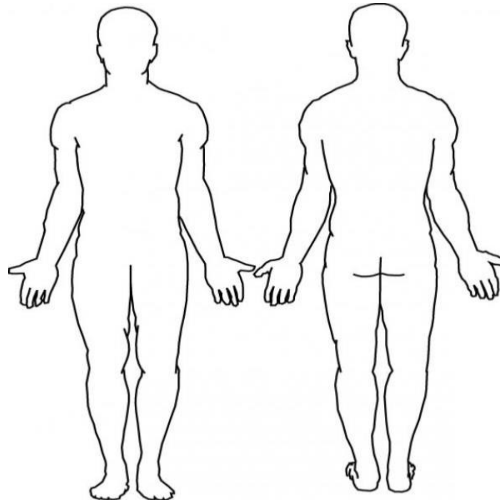
PAIN HISTORY

Chief Complaint (Reason for your visit)?____

Does the pain radiate? If so where?____

Please list any additional areas where you have pain:____

Use this diagram to indicate the area(s) of your pain. Mark the location(s) with an "X"



ONSET OF SYMPTOMS

Approximately when did this pain begin? [ ] < 4 weeks [ ] 4-12 weeks [ ] 3-6 months [ ] 6-12 months
[ ] Other: ____

PAIN DESCRIPTION

Check all of the following that describe your pain:

[ ] Dull/Aching
[ ] Hot/ Burning
[ ] Pressure
[ ] Stabbing/Sharp
[ ] Cramping
[ ] Numbness
[ ] Sharp
[ ] Throbbing
[ ] Squeezing
[ ] Tingling/Pins & Needles
[ ] Shooting
[ ] Tingling

When is your pain at its worst?
[ ] Mornings [ ] Daytime [ ] Evenings [ ] Middle of the night [ ] Always the same

How often does the pain occur?
[ ] Constant [ ] Changes in severity but always present [ ] Intermittent (comes and goes)

Rate your pain at its worst: (with "0" meaning no pain, and "10" being the worst pain imaginable)
0 1 2 3 4 5 6 7 8 9 10

Rate your pain at its best:
0 1 2 3 4 5 6 7 8 9 10

Rate your pain right now:
0 1 2 3 4 5 6 7 8 9 10

MARK THE EFFECT EACH OF THE FOLLOWING HAVE ON YOUR PAIN LEVEL

What makes your pain worse?
[ ] Bending forward [ ] Looking up or down [ ] Sneezing/Coughing
[ ] Bending backward [ ] Changing Position [ ] Rising from seated position
[ ] Going up/down stairs [ ] Lifting [ ] Sitting/Standing a long time
[ ] Any other factors not listed here?____

What makes your pain better?
[ ] Leaning forward [ ] Leaning backward [ ] Lying Flat [ ] Sitting
[ ] Changing Position [ ] Medication [ ] Cold [ ] Heat
[ ] Exercise [ ] Rest [ ] Physical therapy [ ] Injections
[ ] Massage [ ] Assistive device (i.e. cane, walker)
[ ] Any other factors not listed above?____

ASSOCIATED SYMPTOMS

Numbness/Tingling	No	Yes	Where?____________________
Weakness in the arm/leg	No	Yes	____________________
Balance Problems	No	Yes	____________________
Bladder Incontinence	No	Yes	____________________
Bowel Incontinence	No	Yes	____________________
Joint Swelling/Stiffness	No	Yes	____________________
Fevers/chills	No	Yes	____________________

PLEASE MARK ALL OF THE FOLLOWING TREATMENTS YOU HAVE USED FOR PAIN RELIEF

[ ] Physical Therapy [ ] Chiropractic Care [ ] Psychological Therapy [ ] Brace support
[ ] Acupuncture [ ] Hot/Cold Packs [ ] Massage Therapy [ ] Medications
[ ] Injections [ ] Surgery [ ] TENS unit [ ] Other:____________________

INTERVENTIONAL PAIN TREATMENT HISTORY_

[ ] Epidural Steroid Injections [ ] Facet Injections [ ] Nerve blocks [ ] Radiofrequency Ablation
[ ] Trigger point injections [ ] Kyphoplasty [ ] Botox [ ] Spinal Cord Stimulation

CURRENT MEDICATIONS

Are you allergic to any medications? [ ] Yes [ ] No
If so, please list the MEDICATIONS YOU ARE ALLERGIC TO here:

Medication	Reaction (i.e. Rash, Hives, Itching)

Are you taking any blood thinners? [ ] Yes [ ] No. **Name of Doctor who prescribes them:** ____________________

If yes, which ones? [ ] Aspirin [ ] Plavix [ ] Coumadin [ ] Xarelto [ ] Eliquis [ ] Other____________________________

Please list all the medications you are CURRENTLY TAKING including vitamins:

Medication	Dose	How often

PAST MEDICAL HISTORY

Have you ever had or been told you have (Check all that apply):

Cardiovascular/Hematologic:
[ ] Angina
[ ] Heart Disease
[ ] MI, Heart attack, Blocked artery
[ ] Congestive heart failure
[ ] High Blood Pressure
[ ] Peripheral vascular disease
[ ] Arrhythmia (i.e. Atrial Fibrillation)
[ ] Pacemaker
[ ] Angioplasty or heart catheterization
[ ] Rheumatic fever
[ ] Damaged heart valve
[ ] Anemia

Respiratory:
[ ] Asthma
[ ] Emphysema
[ ] Tuberculosis

Metabolic:
[ ] Diabetes
[ ] Hyperthyroidism
[ ] Hypothyroidism
[ ] Steroid use
[ ] Adrenal gland problem

Neurological:
[ ] Epilepsy or seizures
[ ] Fainting spells or dizziness
[ ] Stroke
[ ] Headache/ Migraines
[ ] Multiple Sclerosis

Musculoskeletal/Rheumatologic:
[ ] Fibromyalgia
[ ] Osteoporosis
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Crohn's/Ulcerative colitis

Gastrointestinal:
[ ] Ulcers, heartburn, reflux
[ ] Gallbladder disease
[ ] Diverticulitis or Colitis
[ ] Hepatitis (type____)

Urological:
[ ] Kidney disease
[ ] Shunt, graft, fistula
[ ] Dialysis

Other:
[ ] Depression or Anxiety
[ ] Bipolar disorder
[ ] Schizophrenia
[ ] Cancer: ______________________________
[ ] Skin Condition:_________________________
[ ] Wear Dentures? [ ] Glasses? [ ] Hearing aid?

FAMILY HISTORY

[ ] Arthritis [ ] Cancer [ ] Diabetes [ ] Headaches/Migraines
[ ] High Blood Pressure [ ] Kidney Problems [ ] Liver Problems [ ] Osteoporosis
[ ] Rheumatoid Arthritis [ ] Seizures [ ] Stroke
[ ] Other medical problems: ____

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past including approximates dates:
____Date__________________
____Date__________________
[ ] I have NEVER had any surgical procedures performed

SOCIAL HISTORY

Alcohol use: [ ] Never [ ] Social use [ ] Daily use [ ] Current / Previous Alcoholic
Tobacco use: [ ] Never [ ] Current smoker [ ] Former Smoker [ ] Quit date:________________
Illicit Drug Use: [ ] Never [ ] Formerly used illicit drugs [ ] Currently using illicit drugs

Employment Status:
[ ] Employed Full Time [ ] Employed Part Time [ ] Self Employed [ ] Retired
[ ] Temporary disability [ ] Permanent disability [ ] Unemployed for other reasons
Occupation______________________________When was the last time you worked? ____________________
Are you currently under worker's compensation? [ ] Yes [ ] No
Is there an ongoing lawsuit related to your visit today? [ ] Yes [ ] No

REVIEW OF SYSTEMS

Mark the following symptoms that you *currently* suffer from:

Constitutional:	[ ] Chills [ ] Night sweats [ ] Daytime Fatigue [ ] Fevers [ ] Insomnia [ ] Low sex drive [ ] Unexplained weight loss or weight gain [ ] Skin Rash [ ] Loss of appetite
HEENT:	[ ] Recent vision changes [ ] Loss of vision [ ] Dental problems [ ] Earaches [ ] Hearing problems [ ] Nosebleeds [ ] Sinus problems [ ] Excessive snoring
Cardiovascular:	[ ] Chest pain [ ] Palpitations [ ] Shortness of breath [ ] Fainting Spells [ ] Dizziness [ ] Swelling in hands or feet [ ] Shortness of breath when lying flat
Respiratory:	[ ] Cough [ ] Wheezing [ ] Shortness of breath [ ] Sputum production [ ] Hemoptysis [ ] Frequent respiratory infections
Gastrointestinal:	[ ] Abdominal pain [ ] Diarrhea [ ] Constipation [ ] Heartburn [ ] Nausea/Vomiting [ ] Bowel incontinence
Musculoskeletal:	[ ] Back/Neck pain [ ] Joint pains [ ] Joint stiffness [ ] Joint swelling [ ] Muscle cramps [ ] muscle weakness [ ] muscle atrophy
Genitourinary:	[ ] Flank pain [ ] Blood in urine [ ] Painful urination[ ] Change in urine flow/frequency [ ] Bladder incontinence
Neurological:	[ ]Dizziness [ ]Headaches [ ]Tremors [ ]Numbness/Tingling [ ]Seizures [ ] Loss of coordination
Psychiatric:	[ ] Depressed Mood [ ] Feeling anxious/stressed [ ] Suicidal Thoughts [ ] Thoughts of harming others [ ] Difficulty Sleeping [ ] Difficulty concentrating
Skin:	[ ] Rash [ ] Open sores [ ] Dry skin [ ]Excessive sweating [ ] Red or blue discoloration of skin [ ] Hair loss [ ] Skin hypersensitivity
Endocrine:	[ ] Cold intolerance [ ] Heat intolerance [ ] Excessive thirst [ ] Excessive urination
Hematologic:	[ ] Easy bruising or bleeding [ ] Spontaneous bleeding [ ] Enlarged or tender lymph nodes

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9,
CHAPTER 1703RD EDITION: DEVELOPED BY THE TEXAS PAIN SOCIETY,
APRIL 2008

Name of Patient:____**Date:**____________________________

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers a might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medications include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medications may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I acknowledge that before or throughout the course of my treatment I may be asked to have further tests and examinations. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary. I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from care.

For female patients only:

> To the best of my knowledge **I AM NOT PREGNANT.**
> If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY RESPONSIBILTY** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY. All of the above possible effects of medications have been fully explained to me and I understand that, at present, there have not been studies conducted on the long- term use of many medications i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reason and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medications, physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the potential complications have been explained to me, and I still wish to receive medication for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to lead a more productive and active life. I understand that I may have a chronic illness with a limited chance for complete cure, but the purpose of taking medications regularly is to reduce (though likely not eliminate) my pain, allowing me to enjoy and improve my quality of life. I realize that treatment for some individuals may require prolonged or continuous use of medications, but an appropriate treatment goal may also include the eventual withdrawal from all medications. My treatment plan will be tailored specifically to me. I understand that I may withdraw from this treatment plan and discontinue the use of medication at any time, and I will notify my physician if I decide to do so. I further understand that medical supervision may be required when discontinuing medication.

I understand that no warranty or guarantee has been made regarding the results of any drug therapy or cure for any condition. The long-term use of medications to treat chronic pain is controversial due to uncertainty about the extent of their long-term benefit. I have been given the opportunity to ask questions about my condition, the treatment, the risks of not receiving treatment, and the drug therapy, medical treatment, or diagnostic procedures being used to treat my condition. I have also been informed of the risks and hazards of such drug therapy, treatment, and procedures, and I believe I have sufficient information to provide informed consent.

PAIN MANAGEMENT AGREEMENT

I UNDERSTAND AND AGREE TO THE FOLLOWING:

This Pain Management Agreement relates to my use of any and all medications (e.g., opioids, also referred to as 'narcotics' or 'painkillers,' as well as other prescription medications) prescribed by my physician for the management of chronic pain. I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substances. **Therefore, medications will only be provided as long as I adhere to the rules specified in this agreement.**

My physician may choose to discontinue my medication(s) at any time. Failure to comply with any of the following guidelines and/or conditions may result in the discontinuation of my medication(s) and/or my discharge from care and treatment. Discharge may be immediate in the case of any criminal behavior.

Terms of Agreement:

- My progress will be periodically reviewed, and if the medication(s) are not improving my quality of life, they may be discontinued.
- I will disclose to my physician all medications I am taking, including those prescribed by other physicians.
- I will take my medication(s) exactly as directed by my physician.
- I agree not to share, sell, or otherwise permit others, including family and friends, to have access to my medication(s).
- I will not allow or assist in the misuse or diversion of my medication(s) and will not give or sell them to anyone else.
- All medication(s) must be obtained from one pharmacy, where possible. If a pharmacy change is necessary, I will inform my physician. I will use only one pharmacy and will provide my pharmacist with a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular schedule. If my prescription(s) or medication(s) are lost or stolen, they may NOT BE REPLACED, as they are treated like money.
- Refills will not be ordered before the scheduled refill date. However, early refills may be allowed if I am traveling, provided I make arrangements in advance of my planned departure. Otherwise, I will not expect to receive additional medication before my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) only from one physician unless it is for an emergency, or the medication(s) prescribed by another physician are approved by my physician. If I receive medication(s) prescribed by other doctors without my physician's approval, it may result in the discontinuation of my medication(s) and treatment.
- If my physician determines that my medication(s) do not provide demonstrable benefits to my daily function or quality of life, they may try alternative medication(s) or taper me off all medication(s). I will not hold my physician liable for any issues that arise from discontinuation of medication(s).
- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medications at any time without prior warning. If I test positive for illegal substances (such as marijuana, amphetamines, cocaine, etc.), my

treatment for chronic pain may be terminated. A consultation with, or referral to, an expert may also be necessary, such as submitting to a psychiatric or psychological evaluation by a qualified physician, an addiction counselor, a detoxification and rehabilitation clinic, and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my **active participation** in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.
- I agree to **inform any doctor** who may treat me for other medical problems that I am enrolled in a pain management program, as the use of other medications may cause harm.
- I hereby give my physician **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use or abuse of medications prescribed by other physician(s).
- **I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be grounds for discontinuation of treatment.**
- I must keep all follow-up appointments as recommended by my physician(s), or my treatment may be discontinued.

Certification and Agreement:

I. **I am not currently using illegal drugs or abusing prescription medications**, and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that may impair my judgment.
II. **I have never been involved** in the sale, illegal possession, misuse/diversion, or transport of controlled substances (such as narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (such as marijuana, cocaine, heroin, etc.).
III. **No guarantee or assurance has been made** regarding the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, understanding that it provides me with an opportunity to lead a more productive and active life.
IV. I have reviewed the side effects of the medications that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and risks of these medications, and I agree to their use in the treatment of my chronic pain.**

Patient Signature ____

Pharmacy Name ____

Pharmacy Phone ____

Pharmacy Address ____

Physician Signature ____

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**	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ 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**