Matt E. Hipke, M.D., PLLC
Adolescent Care Team

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Authorization to Disclose Private Health Information

Instructions: Complete all applicable sections to have your private health information disclosed from Dr. Hipke to another provider or requestor. Dr. Hipke will not condition treatment, payment or services on the completion of this form.

I hereby authorize Matt E. Hipke, M.D., PLLC to disclose the following protected health information. I understand a processing fee may apply for the requested information.

- O Entire Medical Record
- O Immunization Records
- O Progress Notes
- O Lab Reports
- O X-ray Report
- O EKG Report
- O Billing Records
- O Medications
- O Consultant Reports
- O Other (Please specify):_____
- O **Talk** with the person(s) listed below about my medical information.

This protected health information is being released for the following purpose: *(check all that apply)*

- O Continued Medical Care
- O Attorney
- O Billing or Filing Claims
- O Other (please specify_____

Dates of Service to be released:

O All Dates of Service or O Specific Dates from_____ to _____
(month/year) *(month/year)*

This authorization shall be in force for 180 days from the signature date unless otherwise specified here: Specific Expiration Date: _____

I understand my records may be released on CD unless I check here: O

The protected health information will be: *(check one)*:

O Delivered to or O Picked up by *(Identification may be required)*

Name_____

Address_____

City_____State_____Zip Code_____

Phone #_____Fax #_____

1. I understand that I have the right to revoke this authorization in writing, at any time by sending written notification to the address on this form with "Attention Privacy Officer" in the address. I understand that a revocation is not effective to the extent that Dr. Hipke has relied on this authorization to disclose protected health information.

2. I understand that information used or 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. I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 (e) and HIPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.

3. A photocopy or electronic reproduction of this authorization is considered as valid as the original.

4. I understand that the records used and disclosed pursuant to this authorization may include information regarding Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment, history of drug or alcohol abuse, mental or behavioral health, and/or other sensitive information.

5. I understand, because I have agreed to the principal of confidentiality, topics considered confidential may be redacted by the Provider.

6. I understand the Provider may receive remuneration from the patient, legal representative or a third party for costs associated in this disclosure as set forth by the Texas State Board of Medical Examiners.

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

8. I may receive a copy of this signed authorization on request at the time it is signed.

_____	_____	_____	_____
Print Name of Patient	Last 4 numbers of Social Security Number	Date of Birth	Today's Date

Signatures:

(PLEASE NOTE: IF THE PATIENT IS 18 OR OLDER, THEY ARE REQUIRED TO SIGN THIS FORM TO MAKE IT VALID.)

Patient/Legal Representative: _____

If Legal Representative, print name here: _____

If Legal Representative, relationship to patient: _____

(Proof of legal authority may be required.)