HIPAA AUTHORIZATION FORM

Patient Name: _____ DOB: _____ Acct/MRN: _____

1. **Patient Preferred Communications:**
   I prefer to receive lab/radiology results, billing/financial, future appointment reminders and other matters as they relate to treatment, payment and healthcare operations to:

   (1) Phone Number: _____

   (2) Email:_____

Unencrypted Email and Text Message Communications:
It is Radiology Partners Houston policy to send encrypted/secure email. By checking the boxes below, you are authorizing Radiology Partners Houston to send email and/or text messages in an unencrypted format. Information sent in an unencrypted manner increases the risk of unauthorized access and disclosure.

□ I would like to receive unencrypted email. Email Address: _____ for:

□ Appointment Reminders □ Breach Notification □ Billing/Financial □ Medical

□ I would like to receive unencrypted text messages. Text Number: _____for:

□ Appointment Reminders □ Billing/Financial

2. **Personal Representatives:** A Personal Representative has the authority to make healthcare decisions on your behalf. Please list any Personal Representatives:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Name: _____ Name:_____

Address: _____ Address: _____

_____ _____

3. Uses and Disclosures:

I, _____, authorize Radiology Partners Houston to disclose my health information to the Personal Representatives, if any, listed above. I understand that the information in my health record my include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. Requested Restrictions: (You have a right to request restrictions on specific uses and disclosures of protected PHI, as well as to request confidential communications in certain circumstances). Please list below:

_____

_____

_____

5. Authorization Statements/Signatures:

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

2. Unless I specify differently below, this authorization will remain in effect until revoked by me. I would like to this authorization to expire: _____

3. I understand that Radiology Partners Houston will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Office Use Only

Revocation

Date Revoked: _____

Initials of Privacy Officer: _____