PROVIDENCE
HEALTHCARE NETWORK

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF HEALTH INFORMATION FROM PROVIDENCE HEALTH CENTER

Providence Health Center
6901 Medical Parkway
Waco, Texas 76712
Tele: (254) 751-4715 Fax: (254) 751-4115

I hereby authorize Providence Health Center to release medical information regarding my care and treatment at Providence Health Center as provided in this Authorization. I understand that this Authorization applies to all records created in the course of my treatment on the date(s) listed below, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, and communicable disease status, including AIDS/HIV.

Patient Name _____ Date(s) of Treatment _____

Social Security Number _____ Birth Date _____ Telephone Number _____

Information to be Used and/or Disclosed.

__History/Physical __Emergency Records __X-ray Films __Other (Specify) _____
__Discharge Summary __Pathology Reports __Billing Records
__Operative Reports __Diagnostic Reports __Complete Medical Record _____

(this health information is referred to in the remainder of this Authorization as "Protected Health Information").

Person(s) to Whom the Use and/or Disclosure May Be Made. The specific persons or class of persons to whom a use and/or disclosure of my Protected Health Information may be made are as follows:

_____

_____

Purpose(s) for the Use and/or Disclosure. The purpose(s) of the use and/or disclosure of my Protected Health Information are as follows:

__Continuing Treatment __Payment __Legal Request __Other (Specify)_____

In consideration of the release of information by Providence Health Center in accordance with this request, I hereby release Providence Health Center, its agents, servants, and employees from any and all claims, demands, or liability of any kind which might arise out of the release of such information and the effects thereof.

This Authorization is subject to revocation at any time in the form of written notice from me, except to the extent that Providence Health Center has already taken action in reliance thereon. If not previously revoked, this Authorization shall expire one hundred eighty (180) days from the date of my signature. A photocopy or facsimile is valid as the original. For additional information about revoking this Authorization, please refer to Section IX in the Providence Organized Healthcare Arrangement Joint Notice of Privacy Practices.

I understand that Providence Health Center may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility of benefits on the provision of this Authorization, except that: (1) it may condition the provision of treatment-related research on the provision of an authorization for the use or disclosure of Protected Health Information for such research; and (2) it may condition the provision of health care that is solely for the purpose of creating Protected Health Information for disclosure to a third party on provision of an authorization for the disclosure of the Protected Health Information to such third party.

I understand that any information disclosed pursuant to this Authorization is subject to redisclosure by the recipient and may no longer be protected by law. I understand that I must be provided with a copy of this signed Authorization.

Signature of Patient or Legally Authorized Representative _____ Date of Signature _____

Relationship to Patient _____ Witness Signature _____