MISSION EAST DALLAS
FAMILY HEALTH CLINIC

Limited Patient Authorization for Disclosure of Protected Health Information (PHI)

Please print all information, then sign and date the form. Thank You!

Patient NAME:	**Social Security Number (SSN):**	**Date of Birth (DOB):**

Effective Period

This authorization for release of information covers **the period of care** from:

☐ (Date)________________________ to (Date)___________________________

☐ All past, present, future periods

Who is Authorized to Receive Information:

I authorize Mission East Dallas to disclose or provide Protected Health Information (PHI) about me to the following person(s) or entity:

NAME:	**Telephone Number(s):**	**Relationship:**
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NAME:	**Telephone Number(s):**	**Relationship:**

☐ I authorize Mission East Dallas to disclose or provide Protected Health Information (PHI) about me to Community Partners (such as detention centers, halfway houses, juvenile justice facilities, foster care facilities or child protective services), who have the legal responsibility for me or my child at certain times.

Information to Be Disclosed:

I authorize Mission East Dallas to disclose or provide types of Protected Health Information (PHI) about me to the following person(s) or entity identified above:

☐ Complete Record

☐ Complete Record, Except ☐ Mental Health Records ☐ Information about communicable diseases (STDs)

☐ Billing Records ☐ Alcohol/Drug Abuse Treatment

☐ Other: ______________________________________

Purpose of Disclosure:

The disclosure/use of the types of Protected Health Information (PHI) noted above is for the following purposes:

☐ At my request ☐ To discuss with my family the care and treatment I receive ☐ Payment by 3rd party, other than health insurance

☐ Other (Specify): ____

Expiration of this Authorization: This authorization will expire 1-Year from the date of your signature below, unless you specify an earlier termination. ***You must submit a new authorization form after the expiration date*** to continue authorization. You have the right to terminate this authorization form at any time by notifying Mission East Dallas ***in writing.*** Please specify expiration date if less than 1-Year:__________________________

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Redisclosure: Mission East Dallas has no control over the person(s) or entity you have listed to receive your Protected Health Information (PHI). Therefore, Protected Health Information (PHI) disclosed under this authorization will no longer be protected by the requirements of this Privacy Rule and will no longer be the responsibility of the practice.

____ ________________________

Patient Signature Date