Indigent Health Care Program
Of Marion County Hospital District
1113 N. Walcott St., Suite B
Jefferson, Texas 75657
(903) 665-2161 Fax (903) 665-8011

HIPPA AUTHORIZATION FORM

Patient's Full Name _____ Patient's Social Security Number/Medical Record Number _____

Address _____ Patient's Date of Birth _____

City, State, Zip Code _____ Patient's Telephone Number _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   _____
2. The following person (or class of persons) may receive disclosure of protected health information about me:
   _____
   His/her/its Name
   _____
   Address
   _____
   City, State, Zip Code
3. The specific information that should be disclosed is (please give of service if possible):
   _____
   _____

UNLESS YOU SIGN HERE. NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSED THIS INFORMATION * _____
NO, DO NOT DISCLOSE THIS INFORMATION *_____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires on _____, 20____ **OR** upon occurrence of the following event that related to me or to the purpose of intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may require to pre-pay for the copies: if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian'/ Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Log #**