AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

REQUEST FOR: Baylor Pathology/ Community Pathology Associates (CPA) ONLY

Baylor College of Medicine

Send this form to: Department of Pathology & Immunology, One Baylor Plaza, MS: BCM315, Houston, TX 77030
Fax: 713-798-8048; Tel: 713-798-4405; Email: path-consults@bcm.edu
Note: Include copy of valid photo ID with authorization.

If this request is **NOT** for Baylor Pathology reports and/or slides, please contact Baylor ROI at TEL: 713-798-1464; FAX: 713-798-5259; Email: roi@bcm.edu

ALL SECTIONS MUST BE COMPLETED FOR A VALID AUTHORIZATION				
I authorize Baylor Pathology/Community Pathology Associates (CPA) to release or give access to the personal health information of the patient to the recipient (both listed below):				
Patient Name:	Date of birth:		Last 4 SSN (optional):	
Patient alias(s):	Patient contact number:			
Recipient's name:	Recipient's email:			
Recipient's address (Street, City, State, & ZIP):				
Recipient's phone:	Recipient's fax:			
Format request (If blank, paper will be provided):	☐ Paper	☐ Encrypted electronic media, if available (USB drive)		
Deliver (If blank, paper will be provided):	☐ Mail	☐ Fax	☐ Encrypted e-mail	☐ Unencrypted email *
***NOTE:** In the event Baylor College of Medicine is not able to accommodate an electronic delivery as requested, an alternative delivery method will be provided. There is some level of risk that a third party could see your PHI without your consent if you choose to receive delivery by unencrypted email. BCM is not responsible for unauthorized access to the PHI contained in an unencrypted email you requested including any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in unsecure email.				
Purpose of disclosure:	☐ Treatment	☐ Disability	☐ Legal	☐ Other:
Disclose the following information:				
Pathology record: ☐	Billing record: ☐	Other (please specify): ☐		
Effective Time Period: This authorization is valid until the patient's death, the patient reaching the age of maturity, or 180 days from the date of signature, whichever is earlier, or upon an Expiration Date or Event (please list):				

SIGNATURE AUTHORIZATION: By signing below, I understand the following:

a. I may refuse to sign this authorization and that it is strictly voluntary.
b. I may revoke this authorization at any time by sending a written revocation to the person/organization listed above. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.
c. Any treatment, payment or my enrollment in any health plan, or my eligibility for benefits will not be affected if I do not sign this Authorization.
d. Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider, or health plan covered by federal or state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
e. I am entitled to receive a copy of this signed authorization.

I have read the above or had it read to me and I authorize the disclosure of the Protected Health Information and noted above.

Signature of Patient/Legal Representative:				Date:
Print name of Patient's Legal Representative:	Relationship to Patient:			
	☐ Self	☐ Parent	☐ Guardian/Ward	☐ Other:
	Attach documents demonstrating your authority to act for the patient.			