

**AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA)**

SECTION A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: _____ **MISD ID #** _____

Persons/Organizations providing the information: (Physician/Hospital name, address, phone number, fax number)

Person/Organizations receiving the information: MISD - Mesquite Education Association

Specific description of information (including dates) Reason for request:

SECTION B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
 - a. What is the purpose or the use of disclosure? _____
 - b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____
2. The patient or the patient's representative must read and initial the following statements:
 - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials _____
 - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials _____

SECTION C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire ____/____/____ (date/month/year) Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. Initials _____

Signature of Patient or Patient's Representative: _____ **Date** _____

Form MUST be completed before signing.

Printed name of Patient's Representative: _____

Relationship to the Patient: _____

Requested paperwork cannot be processed without your signature.

Return this form only to:

**Mesquite Education Association
(MEA)**

2133 North Beltline Road, Mesquite, Texas 75150
Revised 1-15-15

NOTARY:

Subscribed and sworn to before me this _____ day
of _____ 20 _____

_____, Notary Public

Date _____

My commission expires _____

