curative

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization is voluntary and may be used to permit Curative Medical II PLLC, Curative Medical Florida LLC, to use or disclose an individual's protected health information (PHI).

Individuals completing this form should read the form in its entirety before signing and complete all sections that apply to their decisions relating to the use or disclosure of PHI. Curative Medical II PLLC, Curative Medical Florida LLC may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.

☐ As a member (18 years old and older) of Curative Medical II PLLC, Curative Medical Florida LLC, I am requesting disclosure of PHI to the individual as requested below.*

☐ As a parent/guardian of a member (under 18 years old) of Curative Health Plan, I am requesting disclosure of PHI as requested below, and have included proof of identity and legal rights.

Patient Name:* _____ Date of Birth:* _____

Patient Mailing Address:* _____

_____

Date of Birth (MM/DD/YYYY):* _____ Phone:* _____

Member ID Number: _____ Email Address: _____

Effective Date:* ___/___/_____

This authorization will become valid on the date noted above and will remain valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or the date permission is revoked.

RIGHT TO REVOKE: *(implemented within 1 business day of receipt of form or letter)*

I understand that I can withdraw my permission at any time by sending Curative Medical II PLLC, Curative Medical Florida LLC a letter via mail, email, or fax, to the addresses listed at the end of this document. Your letter must also include the member's full name, member number, address, and phone number.

The revocation will have no effect on actions Curative Medical II PLLC, Curative Medical Florida LLC took in reliance on the authorization before receiving a letter to revoke authorization. Researchers are allowed to continue to use the PHI they have gathered before your revocation if they need it in connection with the research study or follow-up to the study.

WHO CAN RECEIVE AND USE THE PROTECTED HEALTH INFORMATION (PHI):

Individual Person: _____

Name: _____ Date of Birth: _____

Mailing Address: _____

_____

Phone: _____

Facility: _____

Name: _____

Mailing Address: _____

_____

Phone: _____ Fax: _____

PLEASE SELECT THOSE THAT APPLY:

- ☐ Self
- ☐ Natural or Adoptive Parent
- ☐ Spouse
- ☐ Foster Parent
- ☐ Legal Guardian
- ☐ Stepparent
- ☐ Legal Representative (someone with legal authority to act on the member's behalf)
- ☐ Other

If the person signing this authorization is not the member or the member is unable to sign the form, you must provide a copy of the health care power of attorney, birth certificate or other relevant document that authorizes you to act on the member's behalf, and proof of identity.

WHAT INFORMATION CAN BE DISCLOSED:

- ☐ All information noted below (if selecting, check only this box)
- ☐ Benefit and Claim Information
- ☐ ID Card Request
- ☐ Home Address Changes
- ☐ Name Spelling and other Personal Information

Your initials are required to release the following information:

_____ Mental Health Information (excluding psychotherapy notes)

_____ Genetic Information (including Genetic Test Results)

_____ Drug, Alcohol or Substance Abuse

_____ HIV/AIDS Test Results/Treatment

_____ Medical Records

Note: There are limitations to the amount of information we can share with others in regard to your account. Note to Parents: These limitations may not affect the legal rights you have to access your child's information by other means, like contacting your child's physician.

HIPAA STATEMENT:

This form is intended for the use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as the term is defined by HIPAA and the Texas Health and Safety Code, must obtain a signed authorization from an individual or the individual's legally authorized representative to disclose that individual's Protected Health Information (PHI).

The Authorization provided by use of the form means the organization, entity or person authorized can disclose, communicate, or send the named individual's PHI to the organization, entity or person identified on the form, including using any electronic means. You have a right to receive a copy of this authorization.

SIGNATURE AND AUTHORIZATION:

I have read this form in its entirety and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosure to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that

information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE (of Individual OR Individual's Legally Authorized Representative):*

_____

Date:* ___/___/_____

Printed Name of Legally Authorized Representative (if applicable):
If representative, specify relationship to the individual:

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See. e.g., Tex. Fam. Code § 32.003).

SIGNATURE (of Minor Individual): _____

Date: ___/___/_____

Members: This completed form or letter of revocation can be submitted to:

Curative Medical II PLLC
Curative Medical FL LLC

900 Congress Ave, Ste 200
Austin, TX 78701

Fax: 833-760-3247

Access the Patient Portal