Submit Request to: 1740 Curie Drive, El Paso TX 79902
Attn: Medical Records
PHONE #: 915-577-7650
FAX #: 915 -577-6998
Email: THOP-ROI-Shared-Mailbox@tenethealth.com

SMCH004

THE HOSPITALS OF PROVIDENCE
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Please check the Campus(es) you are requesting information from:

[ ] East Campus
3280 Joe Battle Blvd (79938)

[ ] Memorial Campus
2001 N. Oregon St (79902)

[ ] Sierra Campus
1625 Medical Center Dr (79902)

[ ] Transmountain Campus
2000 Transmountain Rd (79911)

[ ] ER – Edgemere Campus
12101 Edgemere Blvd (79938)

[ ] Breast & Women's Center West
601 Sunland Park Dr (79912)

[ ] Specialty Campus
1755 Curie Dr. (79902)

Patient's Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes: _____
_____.

If documentation requested is needed for an appointment, please provide date of appointment:_____

MY HIGHLY CONFIDENTIAL INFORMATION:

If and when applicable only, by checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about mental health or mental retardation services
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

PROVIDED COPIES IN THE FORM OF:

☐ Paper format ☐ CD (Electronic format) ☐ via e-Mail format
Radiology only

RECIPIENT: Name of person or class of persons to whom THE HOSPITALS OF PROVIDENCE may disclose my health information: _____
_____.

Address and phone# of the recipient or where my health information should be delivered (if fax# known, please provide): _____
_____.

e-mail address: _____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20___.

☐ Until THE HOSPITALS OF PROVIDENCE fulfills this request.

☐ Until the following event occurs: _____.

PURPOSE: I authorize THE HOSPITALS OF PROVIDENCE to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): _____.

I understand that:

- once THE HOSPITALS OF PROVIDENCE discloses my health information to the recipient, THE HOSPITALS OF PROVIDENCE cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Texas law governing the use and disclosure of my health information.

- THE HOSPITALS OF PROVIDENCE may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

- I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at THE HOSPITALS OF PROVIDENCE; except, however, if my treatment at THE HOSPITALS OF PROVIDENCE is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case THE HOSPITALS OF PROVIDENCE may refuse to treat me if I do not sign this Authorization.

- this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to THE HOSPITALS OF PROVIDENCE's Privacy Office at the address listed below. The revocation will be effective immediately upon THE HOSPITALS OF PROVIDENCE's receipt of my written notice, except that the revocation will not have any effect on any action taken by THE HOSPITALS OF PROVIDENCE in reliance on this Authorization before it received my written notice of revocation.

If I have a Privacy Matter or concern to report, I may contact THE HOSPITALS OF PROVIDENCE's Privacy Officer by mail at 1740 Curie Drive, El Paso, Texas, 79902, or Sarah Arzaga, Market Director of HIM Operations, by telephone at (915) 747-2162 or by email at sarah.arzaga@tenethealth.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize THE HOSPITALS OF PROVIDENCE to use or disclose my health information in the manner described above, and have also attached the required Photo ID.

_____ _____

Signature of Patient Date

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date