CHRISTUS
SOUTHEAST TEXAS
Orthopedic Specialty Center

BEAUMONT BONE &
JOINT INSTITUTE

MEDICAL & FINANCIAL INFORMATION RELEASE: HIPAA (Initial #1 and complete #2)

1. _______(initials) I acknowledge I received a copy of the ***"Notice of Privacy Practices"*** of the CHRISTUS Southeast Texas Orthopedic Specialty Center ("CHRISTUS") and Beaumont Bone & Joint Institute, P.A. ("BBJI").

Complete #2 IF YOU WISH TO AUTHORIZE ANYONE, OTHER THAN YOURSELF, TO DISCUSS DESIGNATED Personal Health Information (PHI) or Financial/Billing Information with CHRISTUS / BBJI ASSOCIATES.

Without this authorization CHRISTUS or BBJI are unable to discuss any information with anyone (including spouse) unless there are extraordinary circumstances, such as an emergency.

2. I hereby authorize the Use and Release of Personal Health Information relating to me, to be released to the following individuals: (Include spouse, parent, child, etc. if applicable)

The DESIGNATED services or dates of service including in this authorization are: ______________________________

____

1. Name____
   Relationship to patient______________________________

2. Name____
   Relationship to patient______________________________

3. Name____
   Relationship to patient______________________________

I understand that if the person receiving this information is not a health plan or health care provider covered by the federal privacy regulations; the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may refuse to sign this Medical information release and that my refusal to sign in no way affects my treatment; payment; enrollment in a health plan; or eligibility for benefits.

Time Limit & Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at CHRISTUS Southeast Texas St. Elizabeth, 2830 Calder, Beaumont, TX 77702 and /or CHRISTUS Southeast Texas St. Mary, 3600 Gates Boulevard, Port Arthur, TX 77642 or online at www.christussetx.org. Unless revoked, this authorization will expire on the following date or event______________________________ or 365 days from the date of signature.

Signature of Patient: ______________________________________ **Date signed:** ________________

PERMANENT PART OF MEDICAL RECORD

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rev. 8/15
BBJ-00060

PATIENT LABEL