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: ____________________________