Texas Property and Casualty Insurance Guaranty Association
9120 Burnet Road, Austin, Texas 78758
(512) 345-9335 FAX (512) 345-9341
Claims Division

HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND MEDICAL RECORDS

Patient name: ______________________
SS#: ______________________
Date of Birth: ______________________

TO WHOM IT MAY CONCERN:

I hereby expressly authorize and direct all of my physicians and health care providers, now and in the future, to disclose my protected health information to the Texas Property and Casualty Insurance Guaranty Association (TPCIGA) and/or any duly assigned representative including a nurse case manager. I direct that my entire Medical Record and all of my protected health records and medical information be provided including, but not limited to, History and Physical; Admission and Discharge Summaries; Operative Reports; Progress Notes and Nursing Notes; Laboratory Reports; Radiology Reports; Immunization Records; Billing Summaries; Consultation Reports; Pathology Reports; Psychological and Psychiatric Assessments; and Medications. I understand that my healthcare providers may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, and/or communicable diseases including HIV/AIDS, this information will be included as part of my medical record and released to TPCIGA. **(Initials__________)**

This authorization shall remain in effect unless and until revocation or cancellation is delivered to the recipient hereof. *A copy of this document shall have the same effect as an original.*

SIGNED: ______________________

PRINTED NAME: ______________________

DATE: ______________________