CITY OF EL PASO DEPARTMENT OF PUBLIC HEALTH (DPH)

Authorization to Use and/or Disclose Protected Health Information Via E-mail

Form Received By	Date

1. Client Name:	1a. Client Social Security Number:
1b. Client Date of Birth:	
2. Applicant Name: Telephone Number: Alternate Telephone Number: E-mail address to which information will be e-mailed:	2a. Authority If you are not the person in Box 1, please describe your authority to act on his or her behalf: ____________________ ____________________ ____________________ ____________________
3. Mailing Address for Records:	3a. City, State, Zip Code:

I hereby authorize **the Department of Public Health** to use and/or disclose the health information described in Sections A — E below.

Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

☐ Medical or Health Information (includes mental health records). Indicate specific information: ____________________
____

☐ HIV-Related Information. Indicate specific information:____________________
____

☐ Social History. Indicate specific information:____________________
____

☐ Other (please specify):____________________

Section B: Person(s) Authorized to Use and/or Receive Information.

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A:

____
(Name or Position of Individual / Entity authorized to receive information)

____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

Section C: Purposes for Which Information will be Used or Disclosed.

The information disclosed may be used by the individual or entity receiving the information for the following purpose(s):

____

Section D: Expiration of Authorization

This authorization will expire on [date or event] ____.
(If no date or event is stated, expiration is one year from the date it is signed.)

Section E: Client's Rights

Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to Privacy Officer at the following address: 5115 El Paso Dr., El Paso TX, 79905.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information by no longer be protected by HIPAA.
- You will be provided with a copy of this Authorization Form, after signing, if **the Department of Public Health** sought the Authorization.

____

Signature of Client & Date

For DPH Employees Use Only

As per DPH Verification Policy, the identity of the requestor/client has been verified through ___________________(driver's license, birth certificate, passport, etc.) and that the person submitting the Authorization to Use and/or Disclose Protected Health Information has the authority to act on behalf of the client.

______________________________	______________________________	______________________________
Name and Title of DPH Representative	Signature of DPH Representative	Date of Determination