By: Fallon S.B. No. 1565

A BILL TO BE ENTITLED

AN ACT

relating to the medical authorization required to release protected health information in a health care liability claim.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 74.052(c), Civil Practice and Remedies Code, is amended to read as follows:

(c) The medical authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Patient Date [~~Place~~] of Birth:_____

Patient Address:_____

_____ Street_____ City, State, ZIP

Patient Telephone:_____ Patient E-mail:_____

NOTICE TO PHYSICIAN OR HEALTH CARE PROVIDER: THIS AUTHORIZATION FORM HAS BEEN AUTHORIZED BY THE TEXAS LEGISLATURE PURSUANT TO SECTION 74.052, CIVIL PRACTICE AND REMEDIES CODE. YOU ARE REQUIRED TO PROVIDE THE MEDICAL AND BILLING RECORDS AS REQUESTED IN THIS AUTHORIZATION.

A. I, _____ (name of patient or authorized representative), hereby authorize _____ (name of physician or other health care provider to whom the notice of health care claim is directed) to obtain and disclose (within the parameters set out

below) the protected health information and associated billing records described below for the following specific purposes (check all that apply):

[ ] To facilitate the investigation and evaluation of the health care claim described in the accompanying Notice of Health Care Claim.

[ ] Defense of any litigation arising out of the claim made the basis of the accompanying Notice of Health Care Claim.

[ ] Other - Specify:_____

B. The health information to be obtained, used, or disclosed extends to and includes the verbal as well as written and electronic and is specifically described as follows:

1. The health information and billing records in the custody of the physicians or health care providers who have examined, evaluated, or treated _____ (patient) in connection with the injuries alleged to have been sustained in connection with the claim asserted in the accompanying Notice of Health Care Claim.

Names and current addresses of treating physicians or health care providers:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

This authorization extends to an additional physician or health care provider that may in the future evaluate, examine, or treat _____ (patient) for injuries alleged in connection with the claim made the basis of the attached Notice of Health Care Claim only if the claimant gives notice to the recipient of the attached Notice of Health Care Claim of that additional physician or health care provider;

2. The health information and billing records in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) during a period commencing five years prior to the incident made the basis of the accompanying Notice of Health Care Claim.

Names and current addresses of treating physicians or health care providers, if applicable:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

C. Exclusions

1. Providers excluded from authorization.

The following constitutes a list of physicians or health care providers possessing health care information concerning _____ (patient) to whom this authorization does not apply because I

contend that such health care information is not relevant to the damages being claimed or to the physical, mental, or emotional condition of _____ (patient) arising out of the claim made the basis of the accompanying Notice of Health Care Claim. List the names of each physician or health care provider to whom this authorization does not extend and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure, or state "none":

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

2. By initialing below, the patient or patient's personal or legal representative excludes the following information from this authorization:

_____ HIV/AIDS test results and/or treatment

_____ Drug/alcohol/substance abuse treatment

_____ Mental health records (mental health records do not include psychotherapy notes)

_____ Genetic information (including genetic test results)

D. The persons or class of persons to whom the patient's health information and billing records will be disclosed or who

will make use of said information are:

1. Any and all physicians or health care providers providing care or treatment to _____ (patient);

2. Any liability insurance entity providing liability insurance coverage or defense to any physician or health care provider to whom Notice of Health Care Claim has been given with regard to the care and treatment of _____ (patient);

3. Any consulting or testifying experts employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

4. Any attorneys (including secretarial, clerical, experts, or paralegal staff) employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of _____ (patient).

E. This authorization shall expire upon resolution of the claim asserted or at the conclusion of any litigation instituted in connection with the subject matter of the Notice of Health Care Claim accompanying this authorization, whichever occurs sooner.

F. I understand that, without exception, I have the right to revoke this authorization at any time by giving notice in writing to the person or persons named in Section B above of my intent to

revoke this authorization. I understand that prior actions taken in reliance on this authorization by a person that had permission to access my protected health information will not be affected. I further understand the consequence of any such revocation as set out in Section 74.052, Civil Practice and Remedies Code.

G. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

H. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Name of Patient

_____

Signature of Patient/Personal or Legal Representative

_____

Description of Personal or Legal Representative's Authority

_____

Date

_____

SECTION 2. This Act takes effect September 1, 2019.