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 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):

[ ] [~~1.~~] To facilitate the investigation and evaluation of the health care claim described in the accompanying Notice of Health Care Claim. [~~; or~~]

[ ] [~~2.~~] 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 [~~the~~] written and electronic and is specifically described as follows:

1. The health information and billing records in the custody of the [~~following~~] 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.___________________________ [~~(Here list the name and current address of all treating physicians or health care providers).~~]

This authorization extends [~~shall extend~~] to an [~~any~~] additional physician [~~physicians~~] or health care provider [~~providers~~] 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 [~~(Here list the name~~] and current addresses [~~address~~] of treating [~~such~~] physicians or health care providers, if applicable: [~~.)~~]

1. ____________________________

2. ____________________________

3. ____________________________

4. ____________________________

5. ____________________________

6. ____________________________

7. ____________________________

8. ________________________

C. Exclusions

1. Providers excluded from authorization.

The [~~Excluded Health Information--the~~] following constitutes a list of physicians or health care providers possessing health care information concerning __________ (patient) to whom [~~which~~] 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 [~~(Here state "none" or list the name~~] 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 [~~of __________ (patient)~~] 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 [~~Patient/Representative~~]

___________

[~~Date~~

[~~___________~~

[~~Name of Patient/Representative~~

1 [__________]

2 Description of Personal or Legal Representative's Authority

3 __________

4 Date

5 ______________

6 SECTION 2. This Act takes effect immediately if it receives
7 a vote of two-thirds of all the members elected to each house, as
8 provided by Section 39, Article III, Texas Constitution. If this
9 Act does not receive the vote necessary for immediate effect, this
10 Act takes effect September 1, 2017.

______________________________ President of the Senate

______________________________ Speaker of the House

I certify that H.B. No. 2891 was passed by the House on April 27, 2017, by the following vote: Yeas 143, Nays 1, 3 present, not voting; and that the House concurred in Senate amendments to H.B. No. 2891 on May 26, 2017, by the following vote: Yeas 144, Nays 0, 3 present, not voting.

______________________________ Chief Clerk of the House

I certify that H.B. No. 2891 was passed by the Senate, with amendments, on May 24, 2017, by the following vote: Yeas 31, Nays 0.

______________________________ Secretary of the Senate

APPROVED: ____________________

Date

____________________

Governor