ELITE HEALTHCARE

Authorization to Release Confidential Health Information/Medical Records

I Hereby Authorize:

- ❑ Elite Healthcare
- ❑ Facility/Doctor Name:_____
  Address:_____
  City:_____ State:_____ Zip:_____
  Phone #:_____ Fax #: _____

To Release the following:

- ❑ Complete Chart Record *(does not include billing information)*
- ❑ Chart Notes: ☐ All ☐ Specify: _____
- ❑ Labs/Reports: ☐ All ☐ Specify: _____
- ❑ Other: Specify: _____

Please check below if you do not want to include any of the following sensitive information relating to:

☐HIV/AIDs ☐mental health conditions ☐substance abuse

From the Health Records of the following Patient:

Patient Name:_____ Date of Birth: _____
Address:_____ Daytime Phone #: _____
Are you authorizing release of your own records? ☐ Yes ☐ No
If not, what is your relationship to the patient? _____

**Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.*

To be Released to:

- ❑ Elite Healthcare
  8700 US HWY 380, Suite 300, Crossroads, TX 76227
  Phone: (940) 365-7033; Fax: (940) 365-7048
- ❑ Facility/Doctor:_____
  Address:_____
  City:_____ State:_____ Zip:_____
  Phone #:_____ Fax#: _____

- I understand that unless revoked, this authorization is valid for 90 days from the date of signing.
- I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law.
- I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.
- I understand that there is a fee of $25 for the first 20 pages and 50 cents for every page thereafter, for records printed and given directly to me.
- I understand that by law, this office has 15 business days to remit records.

_____ _____
Signature of Patient/Legal Representative **Date**

_____ _____
Patient Name (print) **Legal Representative Name/Relationship to Patient**

**We do not accept electronic signatures for a medical records transfer