

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ **Date of Birth:** _____

I authorize **COMPLETE HEALTHCARE SERVICES PA Jasper, Texas 75951 FAX: 409.383.0571 PH:409.384.3430** to **DISCLOSE TO** or **RECEIVE FROM** the above named individual's health information TO or FROM the following individual/organization.

PROVIDER / INDIVIDUAL _____

ADDRESS: _____ **Phone** (____) _____ - _____

CITY/ST/ZIP: _____ **FAX** (____) _____ - _____

For the purpose of: () Continuity of Care () Personal () Litigation () Other _____

- Please release the following:**
- | | |
|--|---|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-Ray/Imaging Reports- from ____/____/____ to ____/____/____ |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> X-Ray Films |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Laboratory Results-from ____/____/____ to ____/____/____ |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> List of Allergies | <input type="checkbox"/> Genetic Testing Information |
| | <input type="checkbox"/> Other (Specify) _____ |

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information. **No, I do not consent to the release of this information.**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date. ____/____/____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Complete Healthcare Services, Compliance Officer or Medical Records Personnel.

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

Relationship to Patient (If Legal Representative) _____ **Witness** _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Complete Healthcare Services' staff and physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

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

Date request completed _____ **# pages copied** _____ **Reviewed Only** _____

Charges \$ _____ **Cash** _____ **Check #** _____ **Initials** _____