# 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 Brookeland, Texas 75931 FAX: 409.698.2800 PH:409.698.9600 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:** ____ **Entire Record**

- _____ **Problem List**
- _____ **Progress Notes**
- _____ **History/Physical Exam**
- _____ **Medication List**
- _____ **Immunization Record**
- _____ **List of Allergies**
- _____**X-Ray/Imaging Reports- from** ____/_____/_____ **to** ____/_____/_____
- _____**X-Ray Films**
- _____**Laboratory Results-from** ____/_____/_____ **to** ____/_____/_____
- _____**EKG Reports**
- _____**Genetic Testing Information**
- _____**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** _____