Medical Records Department · 9011 Poteet Jourdanton Fwy. · San Antonio, TX 78224
Phone (210) 977-1910 · Fax (210) 924-1374

AUTHORIZATION FOR THE USE AND RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ authorize_____

_____ _____ _____
Address Practice Phone Number of Practice Fax Number of Practice

To release information to _____ _____ _____
Name of Practice Address of Practice Phone or Fax Number of Practice

_____ _____ _____
Patient's Name Date of Birth Social Security Number#

_____ _____
Patient's Street Address, City, State & Zip Code Patient's Telephone Number

All information must be filled out in order for request to be fulfilled.

Please check below all of the information that is required. The date of services, type of services, exact level of information to be release, origin of information, etc., if known: From_____To_____

___ Medication List/Problem List

___ Progress Notes/Physician Orders

___ History & Physical

___ Physicians Orders

___ Substance Abuse Reports (specify _____)

___ Mental/Psychiatric/Psychosocial Assessment & Treatments

___ Immunization Records

___ Growth Charts

___ Individual Education Plan & Testing Support (IEP)

___ Communication on Academic Performance & Child Behavior

___ Radiology Reports

___ Laboratory Reports

___ EKG, EEG, EMG Reports

___ Operation Reports/Discharge Summary

___ Consultation with_____

___ Acquired Immunodeficiency Syndrome (AIDS) or test for or infection with human Immunodeficiency virus (HIV)

___ Psychosocial History

___ X-ray

Other Information:_____

_____

_____

I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental Health Records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol / Drug abuse treatment
- ☐ Other (please specify):_____

I understand that if I fail to mark off my complete health record, it will be disclosed.

AUTHORIZATION FOR THE USE AND RELEASE OF PROTECTED HEALTH INFORMATION

This protected health information is being used or disclosed for the following purposes, please check:

☐ At the request of the individual (use only if request is by the patient or personal representative)

☐ Continued Care

This Authorization is effective for a period of (90) days from the signature date or as otherwise specified:

☐ _____ (list expiration date or event),

☐ End of research study (use only if or disclosure is for research), OR

☐ None (use only if disclosure is for research)

After the expiration date, this Authorization to use or disclose this protected health information is no longer valid.

I understand that I have the right to revoke this Authorization , in writing at any time by sending such written notification to the Center's Privacy Officer. Please send your letter to CentroMed at 3750 Commercial Ave., San Antonio, Texas 78221.

I understand that if I later revoke this Authorization, the revocation is not effective for uses or disclosures that the Center has made in reliance on my Authorization. If my Authorization was obtained as a condition of obtaining insurance coverage, the insurer has a legal right to contest a claim if authorization has been revoked.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand CentroMed will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide Authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

☐ If this box is checked, the use or disclosure requested under this consent will result in direct or indirect remuneration to the Center from a third party for marketing purposes.

This Authorization has been read_____ to me or _____ by me, and I understand its meaning.

_____ Date:_____
Signature of Patient or Personal Representative Required

_____
Print Name of Patient or Personal Representative

_____ Date:_____
Witness