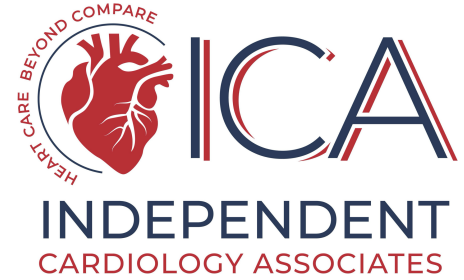


Authorization/Release for Protected Health Information (PHI)



Patient Legal Name (First & Last)		Date of Birth	SSN#	
Address	Apt#	City	State	Zip Code
Phone Number		Email		

I hereby authorize the following facility to disclose Protected Health Information of the Patient listed above:

<p><u>From:</u> Name/Title _____</p> <p>Address _____ _____</p> <p>Phone # _____</p> <p>Fax # _____</p>	<p><u>To:</u> Name/Title _____</p> <p>Address _____ _____</p> <p>Phone # _____</p> <p>Fax # _____</p>
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Reason to Release Protected Health Information

Type of Access Requested _____ Specific Date Range Requested _____

Copies of Records
 Entire Record
 Lab
 Progress Notes
 Inspection of the record
 Pertinent info only
 Imaging/Radiology
 Physicians orders
 ER Records
 Cardiac Studies
 Billing
 History & Physical
 Demographics
 Immunizations
 Consult Report
 Nursing Notes
 Other
 Operative Report
 Medication Record
 Rehabilitation Services

Expiration: This authorization shall expire upon (check one):

- Fulfillment of this request
 Date _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that there may be a fee involved with the fulfillment of this request. **See fee schedule below.**

I understand that the term Complete Chart for release of Protected Health Information mean that **only records generated by this facility will be released.**

I have read the above and authorize the disclosure of the protected health information.
For closed clinics there will always be a fee for copying of records.

Signature of Patient/Parent/Legal Guardian:

_____ Date _____

Fee Schedule

Fees for duplication of Protected Health Information (PHI) are governed by the Texas Administrative Code, Title 22, Part 9, Chapter 165, Rule §165.2. which states the patient shall pay for the reasonable cost of obtaining a copy of medical records.