AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize **Barnard Family Health Centers** to □ release to: □ receive from:

_____ _____
Organization /Person Telephone Number

_____ _____
Address Fax Number

_____
City / State/ Zip Code

_____
Patient Name Date of Birth Social Security

_____
Patient Mailing Address City/ State/ Zip Home Telephone Cell Phone

INFORMATION TO BE USED OR DISCLOSED

Dates of Treatment or Services _____

HIV, Genetic testing, Drug/Alcohol records and Psychiatric information are not included in entire medical record and must be initialed separately.

Please initial all that apply:

___ Physician Office Notes ___ History & Physical Reports ___ Laboratory Reports
___ Radiology Reports ___ Diagnostic Studies/Reports ___ Discharge Summary
___ HIV/AIDS Results/Treatment ___Genetic Information/Results ___ Drug/Alcohol Information
___ Psychiatric Information ___ Billing Records ___ Entire Medical Record
___Other _____

PURPOSE OF USE OR DISCLOSURE:

□ Continued Care □ Attorney/Litigation □ Insurance □ Disability Services
□ Other _____

I authorize the use or disclosure of health information as described above. I understand:

- Treatment may not be conditioned on the completion of the authorization to release health information.
- Fees/charges will comply with all laws and regulations applicable to the release of protected health information. Payment is due prior to release of information.
- I understand that if the Recipient authorized to receive the information is not a covered entity, information released may no longer be protected by Federal or Texas privacy laws.
- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- Proof of identity or guardianship may be requested with this authorization form.
- I may revoke this authorization at any time by submitting a revocation in writing to Barnard Family Health Centers located at 21216 Northwest Freeway, Ste 620 Cypress, TX 77429
- If I revoke this authorization, the revocation will not apply to information already released in good faith before the revocation was received by Barnard Family Health Centers.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Relationship to Patient Print Name of Legally Authorized Representative

_____ _____
Witness – Printed Name/Signature Date

_____
Patient/Legally Authorized Representative Drivers License #

Medical Records Fax # (281) 469-4066

Barnard Family Health Centers
21216 NW Freeway, Suite 620
Cypress, Texas 77429
(281) 469-7704