

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

Patient Name: \_\_\_\_\_ Chart # \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**I authorize the following individual or organization to disclose the above named individuals health information:**

Name (facility/provider releasing information) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date(s) of service requested (if known) from: \_\_\_/\_\_\_/\_\_\_ to: \_\_\_/\_\_\_/\_\_\_

Description of information to be released: (check all that apply)

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> HIV Status Letter     | <input type="checkbox"/> Radiology/Imaging Reports                | from: ___/___/___ to: ___/___/___ |
| <input type="checkbox"/> Progress Notes        | <input type="checkbox"/> EKG Reports                              |                                   |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Laboratory Results                       | from: ___/___/___ to: ___/___/___ |
| <input type="checkbox"/> Immunization Record   | <input type="checkbox"/> Genetic Testing Information              |                                   |
| <input type="checkbox"/> List of Allergies     | <input type="checkbox"/> Other Diagnostic Reports (Specify) _____ |                                   |

Other (Specify) \_\_\_\_\_

**This information may be disclosed TO and used by the following individual or organization:**

Name (facility/provider receiving information) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease 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.

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 will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until \_\_\_/\_\_\_/\_\_\_ (date of event)

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 164.254. 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 Tania Loucel-Gamboa at 713-529-9224.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (Legal Representative)

\_\_\_\_\_  
Witness