# Authorization to Use and Release Information

*Please print. All blanks must be completed.*

Patient Name: _____ Date of Birth: _____ SSN: _____ Sex: _____
Street Address: _____ Home phone: _____
_____ Work phone: _____
E-mail address: _____ Cell phone: _____

I authorize the Center and/or its administrative and clinical staff to release/disclose the following protected health information
☐ to myself **OR** ☐ to ☐ from the following Facility/Physician:

Facility or Physician: _____ Phone: _____

Address: _____ Fax: _____

Please release the following information recorded between the dates _____ to _____:
(Please *initial* applicable lines)

_____ Progress Notes (last 3 most recent) _____History/Physical (most recent) _____ Family Planning related information
_____ Problem List _____ Mental Health, Drug/Alcohol _____ HIV related information
_____ Medication List _____ Labs/Radiology/EKGs Reports _____ Prenatal Care (Antepartum care, delivery.etc.)
_____ Immunization Record _____ Dental _____ Other_____

This protected health information is being used or disclosed for the following purposes: _____
_____. If for another doctor's appointment, when is your appointment?_____

**Facility or Physician: please Fax all records to (979) 595-1732.**

This consent will expire ninety (90) days from the date of my signature, unless otherwise specified. I understand that I may revoke this authorization, except for action already taken, at any time by sending a written notification to the Center's Privacy Contact at:

Attn: Privacy Officer
HealthPoint
3370 S. Texas Avenue Bryan, TX 77802

I understand that if I later revoke this consent, the revocation is not effective for uses or disclosures that the Center has made in reliance on my consent, nor is it effective if my consent was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this Consent may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that my treatment, payment for treatment, enrollment in a health plan, and eligibility for benefits will not be affected if I do not sign this form.

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name of Patient or Representative Relationship to Patient

***Fee for copying records: $5 for up to the first 5 pages, $25 for 6 to 20 pages, and $0.50 per page thereafter.***

*Revised: 07/11/14*
*Approved: 07/11/14*