

Authorization to Release Medical Information

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Requesting Medical Release:

Patient Name: _____ Date of Birth _____ / _____ / _____ SSN: _____ - _____ - _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Facility/Practitioner Authorized to (Release / Receive) my Health Information (Circle one):

Physician Name/Clinic Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

Facility/Agency/Individual(s) Authorized to (Receive / Release) my Health Information:

- | | |
|--|---|
| <input type="checkbox"/> Dr. Darin J. Mitchell | AT: Natural Health Houston |
| <input type="checkbox"/> Dr. Jodi Wilson | 2022 W. Alabama Street |
| <input type="checkbox"/> Dr. Kennedy Tyer | Houston, TX 77098 |
| | Phone: (713) 522-9814 / FAX: (713) 522-3047 |

Health Information that may be used/disclosed is limited to the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Entire Records | <input type="checkbox"/> Diagnostic images/video | <input type="checkbox"/> Other (must be specific): _____ |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Operative Notes | |
| <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> Discharge Summary | |

Authorization:

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing, facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include, alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

I understand further use or disclosure of the authorized information by the above named agency/individual may not be accomplished without my further written authorization. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have the right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

I, hereby authorize the use and disclosure of my private medical records, by way of:

- Mail Fax Phone Oral Email

Patient's Signature or Authorized Party: _____ Date: _____ Time: _____

Relationship to Patient: _____ Interpreter, if utilized: _____