Authorization: Use & Disclosure of Protected Health Information

PATIENT INFORMATION:	INFORMATION RECIPIENT (Release to):
Name:	Name:
Street:	Street:
City:	City:
State/Zip:	State/Zip:
Telephone:	Telephone:
SSN: DOB:	Fax:

SEND INFORMATION FROM:
ALON Family Health 11503 N.W. Military Hwy, Suite 111, San Antonio, TX 78231 Phone: (210) 534-2566 FAX: (833) 316-1848

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Complete health record	☐ Operative report and pathology	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films / images
☐ Photographs, videotapes	☐ Complete billing record	
☐ Abstract of health record (*all typed physician reports and test results)*		

☐ Other, (specify) _____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other (specify) _____ _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I authorize the information source to release my medical or billing records containing information in reference to **Drug and/or Alcohol Abuse** and treatment: ***Initial One:*** **Yes**_____ **No**_____ **Not Applicable** _____

I authorize the information source to release my medical or billing records containing information in reference to **Mental Health or Psychiatric** treatment: ***Initial One:*** **Yes**_____ **No**_____ **Not Applicable** _____

I authorize the information source to release my medical or billing records containing information in reference to **HIV/AIDS (Acquired Immunodeficiency Syndrome)** testing and/or treatment: ***Initial One:*** **Yes** _____**No** ____ **N/A**_____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Record Custodian at the requesting CHRISTUS Santa Rosa Family Health Center. Unless revoked, this authorization will expire on the following date or event _____or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize the information source to release the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Please submit a copy of a valid Photo ID for Identity Verification.

Submit Request with Copy of Photo ID via to: (833) 316-1848, Attn: Records Request