TEXAS REGIONAL CLINIC

Authorization to Use, Disclose, Ispect Personal Health Care Information

Texas Regional Clinic, 8301 Katy Fwy • Suite 101 • Houston, TX 77024
Direct 713.489.1741 • **Fax** 713.984.8481

I Hereby Authorize The Doctors Clinic: or:

Facility / Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Facility / Doctor's Name:_____

___Last two years of all Chart Records (does not include billing information or radiographic images)

___ F**or a Specific physician/ time period:_____**

___Specific: Chart Notes: _____Labs/Reports: _____

Billing Records: _____ Other:_____

Radiographic Studies:_____REPORT__Image CD__

Only the last two years of medical records originated through this healthcare facility will be provided.

From The Health Records Of:

Name: «PatientFullName» **Date of Birth: «PatientDOB»**

Social Security Number: _____Daytime Phone: _____

Are you authorizing the release of your own records? ___Yes ___ No ☐

If not, what is your name and relationship to the patient?

Name: _____ Relationship: _____

Release of certain medical information requires minor's consent. This applies to persons age 13 to 17 for information pertaining to substance abuse and mental health information, or persons age 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To Be Released To:

___ Self (please indicate mailing address below) On or By: ___Paper ___Fax ___Electronically

___ Other :_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

My Rights:

- I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- Unless specifically excluded below, this authorization includes release of specially protected information including referral, diagnosis and treatment information related to:
- (Please check or circle all that apply to **EXCLUDE** the information from authorization and disclosure):

☐ Substance Abuse ☐ Mental Health Conditions ☐ Sexually Transmitted Diseases ☐ HIV/AIDS

- I understand once Texas Regional Clinic has released my health care information to the above named entity, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.
- I understand release of my records may take up to 15 working days.
- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).

I understand a fee may be charged for copies of my medical record not to exceed direction by Department of Health and Human Services' Office for Civil Rights ("OCR") regarding the guidance and FAQs published on February 25, 2016 addressing individuals' rights to access their health information and direct that it be sent to third parties

Patient Signature: _____Date:_____

POA/ Patient Guardian Signature:_____ Date:_____

Please attach a copy of legal documents if you are the legal guardian or holder of Power of Attorney or indicate they are on file in the patients chart**.**