17750 Cali Drive Houston, Texas 77090 281-586-7600 Fax 281-586-5923

Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request

An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization. Please complete a new Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request form.

Patient Name: _____ **Date of Birth**: _____/_____/_____

Address: _____ **City:** _____ **State**: _____ **Zip:** _____

Phone: _____

☐ The said patient above has **declined** to complete this form.

I hereby freely and voluntarily authorize Cypress Creek Hospital to ☐ **RELEASE** ☐**OBTAIN** the following ☐ **TO** ☐**FROM**
(Mark only One) ***(Mark only One)***

Recipient Name: _____**Relationship**:_____

Address: _____ **City:** _____ **State**: _____ **Zip:** _____

Phone: _____**Fax (healthcare provider only):** _____

Preferred Delivery Method: ☐ Fax ☐ Mail ☐ Pick-up

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulation (42 CFR part 2) prohibit their making any further disclosure without my written consent, or as otherwise permitted by such regulations.

Purpose of Disclosure: ☐ Continuum of care ☐ Personal Use ☐ Legal ☐ Other (specify):_____

Covering the period of healthcare from: Specific Date(s): _____ to _____

The information to be released or obtained includes:

- ☐ Discharge Summary
- ☐ Discharge Instructions
- ☐ Psychiatric Evaluation
- ☐ History and Physical
- ☐ Treatment Plan
- ☐ Laboratory Reports
- ☐ Physician Orders
- ☐ Other (specify):_____

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to Cypress Creek Hospital. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. This authorization will expire in 90 days. I have read and understood the information above and with my signature below: authorize the recipient, use and disclosure of the information described in this document for the limited purposes identified herein. **PATIENT MUST SIGN RELEASE REGARDLESS OF AGE IF ALCOHOL AND/OR DRUG TREATMENT IS INVOLVED. **

_____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Parent, Guardian, Authorized Representative (if applicable) **Date**

_____

Printed Name of Witness **Signature of Witness** **Date**

To **revoke** this authorization, sign and date in the space provided below. By signing this revocation, I understand that this revocation will be effective today, except to the extent that CYPRESS CREEK HOSPITAL has already relied upon by authorization to use or disclose my health information as described in the Notice of Privacy Practices.

Signature _____ **Date:** _____**Witness:** _____**Date:** _____

Imprint Patient Information Here:

CYPRESS CREEK HOSPITAL