AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(PLEASE PRINT LEGIBLY)

CARE UNITED MEDICAL CENTER

426 Old FM 548, Suite 124,

Forney, TX 75126

Phone: (972) 564-0044

Fax: (972) 564-0054

PLEASE NOTE: There is a $15.00 per person or a $30.00 per family copy processing fee. Please pay by check or money order. Credit card payments are accepted. Checks should be made payable to: Care United Medical Center, and sent to the above address. Requests are processed upon receipt of payment.

PATIENT INFORMATION:

Patient Name: ___________________________

DOB: ___/___/___ SSN: ____/___/______

Medical Record Number: _______________

Address: ______________________________

City: _________________ State: ______

Zip Code: ___________-______

Phone Number: (_____) ________________

I hereby authorize the use or disclosure of my Protected Health Information (PHI).

FROM:

WHO IS/ARE THE PERSON(S) OR ORGANIZATION(S) AUTHORIZED TO DISCLOSE OR SEND THE INFORMATION?

Name: Care United Medical Center

Address: 426 Old FM 548, Suite 124

City: Forney State: Texas

Zip Code: 75126

Phone: (972) 564-0044

Fax: (972) 564-0054

TO:

WHO IS/ARE THE PERSON(S) OR ORGANIZATION(S) AUTHORIZED TO RECEIVE THE INFORMATION?

Name: ________________________________

Address: ______________________________

City: ___________________ State: _______

Zip Code: _______________

Phone: _______________________________

Fax: __________________________________

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Texas and Federal law concerning the privacy of such information. Failure to provide all information requested, including the pre-payment processing fee, might invalidate or delay the processing of this Authorization.

Purpose of requested use or disclosure: ____

This Authorization applies to the following information (select only one of the following):

____ All health information pertaining to any medical history, or physical condition and treatment received. Please specify date range. From Dates: _________ to __________.

____ Only the following records or types of health information (including any dates): __________________

____ Records will include Alcohol & Drug, Mental Illness, and HIV Results, unless you check this box.

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:____
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization.
- Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, Texas law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

EXPIRATION

This Authorization automatically expires one year from the date signed, unless a different date is provided. [Insert date or event]: ____

SIGNATURE

Date: ________________________________ Signature: _______________________________________

Printed Name: _________________________ Patient Relationship: _______________________________

Date: ________________________________ Witness: ____