

**AUTHORIZATION FOR RELEASE
OF HEALTH INFORMATION**

Medical Record Number:

Patient Name:

**A COPY OF THIS AUTHORIZATION
IS AS VALID AS THE ORIGINAL.**

Date of Birth:

I authorize _____ to release health information to:

Henjum Goucher Reporting Services, L.P.

Name of person or facility to receive health information.

Specify name/title of person to receive health information, if known.

2501 Oak Lawn Ave., Suite 435 Dallas, Texas 75219

Street Address, City, State, Zip Code

tel.(214)521-1188 fax(214)521-1034

Phone Number

Purpose of requested use or disclosure: _____

INFORMATION TO BE RELEASED

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Emergency
Medicine Reports |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Dental Records | <input type="checkbox"/> History & Physical
Exams |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Diagnostic Imaging
Reports |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Progress Notes | | <input type="checkbox"/> Outpatient Clinic
Records |
| <input type="checkbox"/> Other _____ | | |

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R §§2.34 and 2.35).
- I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)
- I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).
- I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

THE PURPOSE OF THIS RELEASE IS (check one or more)

- Continuity of care or discharge planning
- Billing and payment of bill
- At the request of the patient/patient representative
- Other (state reason) _____

NOTICE

Many organizations and individuals, such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- 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: _____
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

SIGNATURE

(Signature of Patient or Patient's Legal Representative)

Date: _____

Printed Name

Time: _____ AM / PM

(If signed by someone other than the patient, state your legal relationship to the patient/authority).

Witness or Translator