AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: *(include previous or other names used)* _____

Driver license / Gov't ID No: _____ **State:** _____

Requestor's Name: _____ ***A CLEAR PHOTOCOPY OF YOUR ID MUST ACCOMPANY THIS AUTHORIZATION***

Address: *(City, ST, Zip)* _____

Date of Birth: _____ **Patient Number or Social Security Number:** _____

Email: _____

Telephone Number: _____ **Fax Number:** _____

Patient Information Is Needed For: ☐ **Continuing Medical Care** ☐ **Personal Use** ☐ **Insurance** ☐ **Legal Purposes** ☐ **Social Security/Disability** ☐ **School** ☐ **Other:**

I authorize the release of medical records from: _____ **(doctor or medical practice) which are held by a custodian for the medical practice. The custodian reserves the right to verify my identity / guardianship / power of attorney or other authority and will only provide records upon receipt of this signed Authorization.**

CHOOSE ONE:

____ Complete record OR ____Partial Records of care from _____ to _____ only

CHOOSE ONE:

____Electronic Copy Only ____Paper Copy Only **Paper copies will incur shipping costs to invoices.**

Please release the requested medical records to: _____

Address, City, State, ZIP _____

I specifically authorize the use and disclosure of all of my medical record, except for the following specifically identified documents:
YOU DO NOT HAVE TO AUTHORIZE RELEASE OF AIDS/HIV-RELATED INFORMATION.

This authorization will expire on the 90th day of the signing unless a lesser date is specified below:
By signing this Authorization, I am giving my authorization for custodian to disclose my PHI, as described above. The information to be disclosed may include information relating to: (1) acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed.

Additionally, this authorization permits the custodian to deliver records to the identified address via 3rd Party including US Postal Service, Fedex, or UPS shipment.

I understand that I may revoke this Authorization at any time by notifying the custodian in writing at VeriTrust - Medical Records, P.O. Box 22737, Houston, TX 77227 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information disclosed before the custodian received my written revocation.

If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization.

The confidentiality of the Information disclosed hereunder is protected by federal law. Federal regulations (42 C.F.R. Pt. 2) may prohibit you from making any further disclosure without the specific written consent of the patient. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____

Signature of Patient or Authorized Representative

Date:_____**, 20____**

Print name_____ **Relationship:** _____

PLEASE NOTE THAT ALL RECORDS ARE AUTOMATICALLY SENT ELECTRONICALLY UNLESS OTHERWISED MARKED ON FORM. ALL SHIPPING COSTS ARE THE RESPONSIBILITY OF THE REQUESTOR AS WELL AS ALL OTHER FEES ASSOCIATED WITH THE REQUEST.