CALVARY
Medical Clinic

Where Your Healing Begins

Authorization for Use and Disclosure of Protected Health Information

Patient Identification:
Printed Name: _____

Date of Birth: _____ **Telephone #:** _____

Address: _____

Information is to be released: ☐ **Pick-up** ☐ **Fax** _____

From: _____
_____
Address _____
City _____ State _____Zip _____
Phone # _____Fax # _____

To: _____
_____
Address _____
City _____ State _____Zip _____
Phone # _____ Fax#_____

Please check type of information to be released: (A separate Release is required for Psychiatric records)

All Records last 2 years	All Records last _____ years	X-ray reports
Progress Notes	Consultation Reports	x-ray films/images
Laboratory Test results	Other (specify)	

Purpose of Request:

Treatment Appt Date: _____	At the request of the patient	Billing or claims payment
Other (specify)		

Drug and/or Alcohol, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in by instructions above.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by resubmitting a notice in writing to the facility Privacy Officer at Calvary Medical Clinic, 108 S. William Barnett Ave., Cleveland, TX 77327. Unless revoked, this authorization will expire 365 days from date of signature.

Re-Disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

PLEASE INITIAL: _____ Fee for Copying Requested Information: I understand that there may be a fee charged for the copying of the requested information. I have been notified of this policy and agree to pay accordingly.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed**. I authorize Calvary Medical Clinic to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Witness: _____ Witness: _____

Identity of Requestor Verified: □ Photo ID □ Matching Signature □ Other (specify) _____ Verified by: _____