

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

Please read before signing: DO NOT SIGN BLANK FORM

Patient Name: _____ DOB: _____ SS# (LAST 4) _____

PURPOSE OF DISCLOSURE: (CHECK ONE):

Continuity of Care / Care Coordination

*I authorize and direct the release of the following confidential health information to Kosse Community Health Clinic (address in header) from health care providers and facilities involved in my **current treatment and/or prior treatment within the past** ____ months/years, including primary care providers, specialists, hospitals, laboratories, and imaging centers. (If check, may use unless revoked. _____ initials)*

Release of Medical Records to a Third Party (one time use)

I authorize and direct: Kosse Community Health Clinic, 206 N Narcissus St, Kosse, TX 76653

To release the following confidential health information to (recipient):

Name/Organization: _____

Address: _____

Fax: _____ Email: _____

Reason: **Auto/PPI insurance** **Attorney** **Disability** **Personal use**

Other: _____

DATES OF SERVICE to release: **All dates** OR From _____ to _____

INFORMATION TO BE RELEASED (check all that apply):

<input type="checkbox"/> Demographic	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Emergency Room Record
<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Radiology Reports / CD
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG/CT scan/MRI/US	<input type="checkbox"/> Nurses' Notes
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Physician's Notes	<input type="checkbox"/> Entire Chart
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Immunization	<input type="checkbox"/> Other

SENSITIVE INFORMATION (release ONLY if initialed):

Mental health/behavioral health records HIV/STD info

Alcohol/Drug treatment (SUD) records Other sensitive information: _____

DELIVERY METHOD (check one): Mail Fax Secure email

Patient Portal Other: _____ **PLEASE NO CDs**

If email is requested: Email address _____ I understand unencrypted email can be read by others.



KOSSE COMMUNITY HEALTH CLINIC

206 N Narcissus St
Kosse, Texas 76653
Tel: 254-375-7001 Fax: 254-375-2233

FEES: I understand there may be a charge for copies as permitted by Texas law, unless records are sent directly to another health care provider.

PATIENT RIGHTS AND HIPAA REQUIRED STATEMENTS:

- 1) I understand that I may revoke this authorization at any time by submitting a written request to the releasing facility's Health Information Management/Medical Records Department at the address above, except to the extent action has already been taken in reliance on this authorization.
- 2) I understand that this authorization is voluntary and that treatment, payment, enrollment, or eligibility for benefits are not conditioned by signing.
- 3) I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
- 4) I have the right to receive a copy of this signed authorization.

EXPIRATION: This authorization expires in 180 days from the date signed OR when a request to revoke has been signed.

SIGNATURES:

Signature of Patient

Printed name of Patient

Date

OR

Signature of legal representative

Printed name of representative

Date

Relationship/authority to act for patient _____

(If you sign as the patient's personal representative, you must describe your authority (e.g., parent of minor, legal guardian, medical power of attorney, executor of estate.)