AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____

Social Security #: _____ **Date of Birth:** _____

I hereby authorize and request:	To provide to/receive from:
Facility: IntraCare North Hospital	**Facility:** _____
Person: Health Information Services	**Person:** _____
Address: 1120 Cypress Station Drive	**Address:** _____
City/State/Zip: Houston, Texas 77090	**City/State/Zip:** _____
Telephone: (281) 893-7200	**Telephone:** _____
Fax: (281) 893-0360	**Fax:** _____

Regarding the above referenced medical record from the dates of: _____**to**_____

The following information: (check all that apply)

_____ Discharge Summary _____ Psychiatric/Psychological Evaluation/Report _____ History & Physical

_____ Aftercare Plan _____ Consultations _____ Radiology _____ Laboratory Reports

_____ Other (Specify): _____

Purpose for the release of Information (check all that apply):

_____ Determine Eligibility-SS Disability, etc. _____ Continuity of Care/Monitor Medical Status

_____ Admission/Intake/Placement/Transfer _____ Legal Proceedings _____ Personal Use

_____ Other (Specify): _____

I understand that my medical record may include information regarding diagnosis and treatment of **DRUG, ALCOHOL, PSYCHIATRIC DISORDERS, SEXUALLY TRANSMITTED DISEASES, HIV OR AIDS INFORMATION.**

I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of healthcare with the following exception: Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is to the sole purpose of creating protected health information for disclosure to a third party. I understand that I am entitled to receive a copy of this authorization.

This authorization is valid for a period of no longer than reasonably necessary to serve the purpose for which it is given, in any event not to exceed 90 days or with the following date or event: _____

If I am signing as a parent/legally authorized representative/managing conservator of a minor or legally authorized representative of the person of an adult, I understand the information disclosed/received may contain information/references to my family or myself.

_____ DATE: _____

Signature of client 16 years of age or older

_____ _____ DATE: _____

Signature of legally authorized representative Relationship

_____ DATE: _____

Signature of witness

You have the right to revoke this authorization. To revoke this authorization, sign and date in the space provided below. By signing this revocation I understand that this revocation will be effective today, except to the extent that IntraCare Hospital has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices.

_____ **DATE:** _____

Signature

_____ **DATE:** _____

Witness