Authorization For Release and Disclosure of Protected Health Information

In accordance with state law and regulatory agency requirement, the health record is the property of CHARM. I herby authorize the Medical records custodian to release information from the medical records of:

Patient Name:_____ DOB:_____ SSN:_____

Address:_____City/St/Zip:_____

Telephone:_____ Alt.Contact:_____

Information May Be Released To:

Center for Healing and Regenerative Medicine (CHARM
10815 FM 2222 Bldg 3B, Ste 200
Austin, TX 78730
(512) 614-3300;
(512) 614-372-1665 fax

From: Facility or Physician:

Name:_____

Address:_____

City/ST/Zip:_____

Phone/Fax:_____

Please Release the following Information:

☐ Problem List ☐ X-ray & Films reports ☐ History & Physical ☐ Medication list
☐ Progress Notes ☐ Lab results ☐ Other:_____

This information is necessary for the following purpose:

☐ Continued patient care ☐ Personal use ☐ Attorney/ Legal ☐ Insurance
☐ Other (Specify):_____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol / drug abuse.
2. I understand that I have a right to revoke this authorization at anytime. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent claim under my policy, unless otherwise revoked, this authorization will expire in 1 year or the following date:_____. If I fail to specify a date the authorization will expire in 12 months.
3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this in order to assure treatment. I understand that with certain exceptions, I may inspect or copy the information to used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (512) 614-3300.

_____ _____
Patient signature or legal representative Date

_____ _____
Relationship to patient Witness