SignatureCare EMERGENCY CENTER

GENERAL MEDICAL RECORDS RELEASE
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO BE COMPLETED BY THE PATIENT OR LEGAL GUARDIAN/PATIENT REPRESENTATIVE IF PATIENT IS A MINOR CHILD

PATIENT LABEL

When requested, I authorize SignatureCare Emergency Center to disclose/release/receive the following information:

(Place [X] next to the records you are requesting below)

____ALL Records ____Radiology Records ____Pathology Records

____Laboratory Records ____Pharmacy/Prescription Records _____Other: _____

These records are for services provided on the following date(s): _____

PATIENT INFORMATION:

PATIENT'S NAME: _____PATIENT'S DOB _____

PATIENT'S ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease(s), you are hereby authorizing disclosure of this information.

MEDICAL RECORD REQUESTER INFORMATION

REQUESTER'S NAME _____ REQUESTER'S PHONE # _____

COMPANY/ORG. NAME _____ EMAIL _____

REASON FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information may be used/disclosed for each of the following purposes (check all that apply):

_____ At my request (can only be marked by the patient) _____ For continuity of medical care

_____ For payment/insurance purposes _____ For Employment purposes

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Other: _____

EXPIRATION

This authorization shall expire no later than **one month after date of service** or upon the following event: _____ (Whichever is sooner), and may not be valid for greater than one year from the date of signature for SignatureCare Emergency Center records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the SignatureCare Emergency Center Medical Records Department at 8910 HWY 6 SOUTH HOUSTON, TX 77083.

_____ _____

SIGNATURE OF EMERGENCY ROOM PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE **DATE**

_____ _____

PRINTED NAME OF PATIENT/REPRESENTATIVE

REPRESENTATIVE'S AUTHORITY TO SIGN (i.e. PARENT, GUARDIAN, POWER OF ATTORNEY FOR HEALTHCARE, EXECUTOR- MUST HAVE DOCUMENTATION)