# CYPRESS CREEK HOSPITAL

17750 Cali Drive Houston, Texas 77090 281-586-7600 Fax 281-586-5923

## Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request

*An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization. Please complete a new Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request form.*

**Patient Name:** _____ **Date of Birth:** ____/____/____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____

☐ The said patient above has **declined** to complete this form.

I hereby freely and voluntarily authorize Cypress Creek Hospital to ☐ **RELEASE** ☐**OBTAIN** the following ☐ **TO** ☐**FROM**
*(Mark only One)* *(Mark only One)*

**Recipient Name:** _____ **Relationship:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Fax (healthcare provider only):** _____

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulation (42 CFR part 2) prohibit their making any further disclosure without my written consent, or as otherwise permitted by such regulations.

**Purpose of Disclosure:** ☐ Continuum of care ☐ Personal Use ☐ Legal ☐ Other (specify):_____

**Covering the period of healthcare from:** Specific Date(s): _____ to _____

*****The information to be released includes:**

- ☐ Discharge Summary
- ☐ Psychiatric History/ Mental Status Examination
- ☐ History and Physical
- ☐ Psychological Testing
- ☐ Treatment Plan
- ☐ Laboratory Reports
- ☐ Physician Orders
- ☐ Other (specify):_____

***State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:***

**Alcohol, Drug, or Substance Abuse Records** ☐ **Yes** ☐ **No** **Mental Health** ☐ **Yes** ☐ **No**

**HIV Testing and Results** ☐ **Yes** ☐ **No** **Psychotherapy Records** ☐ **Yes** ☐ **No** ***(must have physician orders)***

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to Cypress Creek Hospital. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE. I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making to the hospital for service provided. This authorization will expire in 90 days.
I have read and understood the information above and with my signature below: authorize the recipient, use and disclosure of the information described in this document for the limited purposes identified herein. **PATIENT/RESIDENT MUST SIGN RELEASE REGARDLESS OF AGE IF ALCOHOL AND/OR DRUG TREATMENT IS INVOLVED. **

_____

**Signature of Patient or Personal Representative** **Date**

_____

**Printed Name of Parent, Guardian, Authorized Representative (if applicable)** **Date**

_____

**Printed Name of Witness** **Signature of Witness** **Date**

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 CYPRESS CREEK HOSPITAL has already relied upon by authorization to use or disclose my health information as described in the Notice of Privacy Practices.

**Signature** _____ **Date:** _____ **Witness:** _____ **Date:** _____