

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name	Date of Birth	SS#	MR#		
Address			Telephone		
<p>I hereby authorize _____ <i>Physician or Facility name</i></p> <p>To release information from the medical records of _____ <i>Patient name</i></p> <p>For treatment dates: _____ <i>Specify dates if known of if a selection of records is desired rather than all records.</i></p> <p>For the following purpose: <input type="checkbox"/> Archiving <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> To: MyHealthArchive FAX (832) 565-9006 (strongly prefer FAXing over mailing: Please include this form in any FAXes)</p> <p style="margin-left: 40px;">PatientCentral Technologies, LLC, 1177 West Loop South, Suite 1100, Houston, TX 77027 Phone (888) 788 8873</p> <p>OR <i>(if the records are to go to the MyHealthArchive member directly for uploading)</i></p> <p><input type="checkbox"/> To: _____ <i>Name and Address of person to whom records are to be sent</i></p> <p style="margin-left: 40px;">Fax # <i>(Please include this form in any FAXes)</i> _____ Phone # _____</p>					
<p>Please send only the portions of the medical record checked below.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> All physician notes/letters/dictations <input type="checkbox"/> Lab (slides, blocks, specimens & tissue samples) <input type="checkbox"/> H+P /Consults/DC summaries <input type="checkbox"/> Imaging/Radiology/Nuclear Medicine <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Orders <input type="checkbox"/> Echocardiography, etc <input type="checkbox"/> Face Sheet <input type="checkbox"/> Operative/Procedure Report </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Entire Record <u>EXCLUDING</u> - HIV Testing & Chemical Dependency. <input type="checkbox"/> Entire Record <u>INCLUDING</u> - HIV Testing & Chemical Dependency. <input type="checkbox"/> Entire Record <u>INCLUDING</u> - HIV Testing Only. <input type="checkbox"/> Entire Record <u>INCLUDING</u> - Chemical Dependency Only. <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other _____ </td> </tr> </table>				<input type="checkbox"/> All physician notes/letters/dictations <input type="checkbox"/> Lab (slides, blocks, specimens & tissue samples) <input type="checkbox"/> H+P /Consults/DC summaries <input type="checkbox"/> Imaging/Radiology/Nuclear Medicine <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Orders <input type="checkbox"/> Echocardiography, etc <input type="checkbox"/> Face Sheet <input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Entire Record <u>EXCLUDING</u> - HIV Testing & Chemical Dependency. <input type="checkbox"/> Entire Record <u>INCLUDING</u> - HIV Testing & Chemical Dependency. <input type="checkbox"/> Entire Record <u>INCLUDING</u> - HIV Testing Only. <input type="checkbox"/> Entire Record <u>INCLUDING</u> - Chemical Dependency Only. <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other _____
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<p>This authorization is continuing in nature and remains effective until revoked. A copy of this authorization shall be considered as effective as the original.</p>					
<p>I, the undersigned, have read this <i>AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS</i>, and authorize the above named health care provider to provide copies of the Protected Health Information records checked in the box above this authorization. No revocation of this authorization shall be effective as to any action taken in reliance upon it until such revocation is delivered in writing. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that I may receive a copy of this authorization. I hereby hold harmless the above named facility and any parent company from all liability and damages resulting from the lawful release of my Protected Health Information records.</p>					
Date _____	Signature of Patient/Parent/Conservator/Guardian _____	Authority/Relationship to Patient _____			