OmniPoint Health
World-Class Care. Hometown Service.

# Authorization for Disclosure of Protected Health Information

Patient Name _____ Date of Birth: _____

Address _____ Last 4 digits of SS# _____

Phone # _____ Email Address _____

**I request that my PHI (Protected Health Information) from Chambers Health (CCPHD) be disclosed to:**

Recipient Name _____ Date of Birth: _____

Email Address _____ *Fax # _____

*Fax is only for Healthcare Providers

**I authorize the following PHI to be released from my health record(s):**

☐ Entire Medical Record ☐ Immunization Record ☐ Laboratory Report(s)

☐ Emergency Room Record(s) ☐ Pathology Report ☐ Radiology/Imaging Report(s)

☐ Hospital Stay Record(s) ☐ Surgery/Operative Report(s) ☐ Billing Record

☐ Other _____

I understand that information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

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

Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____

HIV Testing and Results □ Yes □ No Dates: _____

Mental Health □ Yes □ No Dates: _____

Psychotherapy Records □ Yes □ No Dates: _____

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

☐ All past, present and future encounters/visits

Purpose for requesting information: ☐ Insurance ☐ Legal ☐ Personal ☐ Continuation of Care ☐ Other (specify below):

_____

**Disclosure Format** *(Paper is default if not marked)*: ☐ **Hand Delivery** – paper format ☐ **US Mail** – paper format

☐ **Fax** (healthcare provider only) ☐ **E-mail** (**secure** format) ☐ **E-mail** (**unsecure** format, i.e., Gmail, Yahoo)

☐ **CD/Flash drive** – secure format ☐ **Other** (please specify): _____

**By signing this authorization form, I understand that:**

- Requests for copies of medical records are subject to reproduction fees in accordance with state/federal regulations.
- I have the right to revoke this authorization at any time in writing and presented or mailed to: **OmniPoint Health, Attention: Health Information Management Department, P.O. Box 398, Anahuac, Texas 77514.** Revocation will not apply to any information that was released prior to receiving the revocation request.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this expiration will expire 180 days from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether this authorization is signed.
- Disclosure of information carries potential of unauthorized redisclosure and may not be protected by federal confidentiality rules.

Patient or Authorized Representative Signature _____ Date _____

Print Name Relationship to Patient (if applicable) _____

(For Office Use Only) Account Number: _____ Released by: _____ Date _____