11240 FM 1960 West, Ste 210
Houston TX 77065
Phone: 281-469-7400
Toll Free: 1-877-563-0817
Fax: 281-469-7403

Authorization for Disclosure of Protected Health Information to NW Cypress Pediatrics and Family Medicine (NWCPF)

This completed form authorizes a third party to disclose a patient's protected health information to NWCPF

I. Patient's Name: ____ Birth Date: _______________

Patient's Address: ____Home Phone: __________________

City, State, Zip: __________________________________ Dates of Service: ________________________

II. Check the reports to be disclosed:

( ) Abstract - includes Face Sheet, Discharge Summary, History and Physical Exam, Operative and Pathology Reports, Consultation Reports, Radiology Reports and EEGs

Or:

( ) Discharge Summary
( ) History and Physical Exam
( ) Consultation Reports
( ) Progress Notes
( ) Radiology Reports
( ) Laboratory Reports
( ) Pathology Reports
( ) Operative Reports
( ) Clinic/Outpatient Record
Which clinic or Dr? __________________________
( ) Billing Claims Forms
( ) Itemized Statement of Charges
( ) Other, specify: ____________________________
( ) All Information

Or, for mental health records (May require physician/psychologist approval):

( ) Psychiatric/Mental Health Records
( ) LSC/CAP Records
( ) Neuropsychological Testing
( ) Other, specify: ___________________________
( ) All information

III. Records released from: Name: ____Phone: ______________

Mailing Address: ____Fax:__________________

____

IV. Records released to: Name: ____Phone: ________________

Mailing Address: ____Fax:___________________

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V. For the purpose of: ____

VI. I authorize the third party named in Section III above to disclose the protected health information about myself (or the patient) as described above to NWCPF as provided in Section IV above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
  Expiration: ____
- I may revoke this authorization at any time by notifying NWCPF in writing. If I revoke authorization I understand that it will have no effect on actions NWCPF took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- I understand that NWCPF may not condition treatment or payment on my completion of this form.
- NWCPF reserves the right to verify my identity/guardoanship..

Signature: ____ Date____________________

Printed Name: ______________________________________ Relationship to Patient: __________________