Environmental Health Center–Dallas

8345 Walnut Hill Lane-Suite 220
Dallas, Texas 75231
Medical Records Phone: (214) 373-5163/Medical Records Fax: (214) 696-4107

Authorization for Use and Disclosure of Protected Health Information-Medical Record Copy Request

● Patient's Name (please PRINT)-_____

D.O.B.-_____/_____/_____ Area Code + Phone #-_____

I, the undersigned, hereby authorize the Environmental Health Center-Dallas to release the above named individual's private health information as specified below.

● **DATES OF SERVICE REQUESTED:**

From: (MM/DD/YY) _____ thru (MM/DD/YY) _____ **OR** (specific date of service) _____

OR *All Dates of Service*

● **INFORMATION TO BE RELEASED:** (Medical Records=$25.00 for the first 20 pages + .50 cents per page thereafter)
–PROCESSING TIME =15 business days

□ Name □ Address □ Phone □ Social Security Number □ Medications □ Other Physicians Records

□ Immunotherapy Requisitions/Contents of Vials □ Skin Testing Endpoints/Symptom Sheets □ Consulting Physician Reports

□ Physician Visit Notes □ Lab/X-Ray/Diagnostic Testing □ I.V. Therapy □ Oxygen Therapy □ Sauna Therapy □ Nutritional Consultation

Other (specify)_____ **OR** *All Treatment Records*

● **REASON/PURPOSE FOR THE RELEASE OF THIS INFORMATION:** (check all that apply)

□Continuing Medical Care □Insurance □Personal Use □Attorney □Social Security/Disability □Other (specify) _____

● **AUTHORIZATION FOR RELEASE OF INFORMATION SPECIFICALLY PROTECTED BY STATE AND FEDERAL LAW:**

I specifically authorize release of confidential health information contained in this individual's health record which may include information related to: **(please INITIAL each blank as applicable and "X" for non-applicable)**

_____ Behavioral or Mental Health Services **(Neuro-Psychological Evaluation)** _____ Genetic Testing _____ Alcohol and/or Drug Abuse

_____ Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) _____ Sexually Transmitted Diseases

● **I AUTHORIZE RELEASE OF THE REQUESTED MEDICAL INFORMATION TO:**

(Who do you want EHC-D to MAIL/GIVE this information to?)

Name (print NAME)-_____

Address-_____

City-_____ State-_____ Zip Code-_____

OR _____ The above named individual is authorized to **pick-up this information** at the EHC-D. Please contact me/them at:

Area Code + Phone #-_____ when this information is available.

-A copy/facsimile of this authorization shall have the same force as an original.
-I understand that the patient, or other person authorized to consent, may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. A written notice of revocation must be sent to-Medical Records @ EHC-D, 8345 Walnut Hill Lane, Suite 220-Dallas, Texas 75231.
-Without previous express revocation, this authorization will automatically expire upon filling the purpose or need for information as specified above.
-By signing this authorization I acknowledge that I have read and fully understand the above statements and consent to the release of private health information for the purpose stated above.

● _____ _____
Date of Request Signature of **Patient** or **Legal Guardian**

For Office Use Only-Request Completed On: Initials: