

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-Form Completion 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.

FORM COMPLETION (\$25.00 + applicable records fees)

-PROCESSING TIME=15 business days

(all areas of the form which require the patient's signature must be signed before it is turned in for completion)

If you are submitting FMLA (Family Medical Leave Act) forms for completion you must provide us with the dates that you will be out of work:

_____ to _____

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 _____ Genetic Testing _____ Alcohol and/or Drug Abuse
(Neuro-Psychological Evaluation)

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

I AUTHORIZE RELEASE OF THE REQUESTED MEDICAL INFORMATION TO: (complete **ONE** area ONLY)

(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:

MR02-01.06