AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I HEREBY AUTHORIZE: YOUENS AND DUCHICELA CLINIC

Dr. Jorge Duchicela Dr. Olga Duchicela

402 Youens Drive

Weimar, Texas 78962

Tel: 979-725-8545 Fax: 979-725-8287

To disclose the below named individual's health information to:

_____

Name of Doctor / Facility

_____

Street Address City State Zip

_____

Phone Number Fax Number

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated below and any other use of this information without the consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire on the following date, event or condition:_____
If I fail to specify an expiration date, event or condition this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager.

Reason for Disclosure

___ Continuation of Care
___ Billing / Claims
___ Insurance
___ Legal Purposes
___ Other:_____

Please release the following:

___ Complete Chart
___ Progress Notes / H&P
___ Medication List
___ Immunization Record
___ Xray / Imaging Reports
___ Laboratory Results
___ EKG Reports
___ Other (Specify) _____

For Dates: _____ To: _____

_____

Patient Name Date of Birth Social Security #

_____

Address City State Zip

_____

Patient / Parent of Minor / Guardian Signature Date