CYPRESS POINTE
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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Full Name: _____ Date of Birth: _____ Phone #: _____

Authority to Release Protected Health Information

I hereby authorize _____, to **release** the information indicated below to:
(Doctor or Mid-Level Name)

Physician Office/Requesting Facility: _____ Provider: _____

Address: _____

Phone #: _____ Fax #: _____

Covering the Periods of Health Care

I authorize the release of the health records indicated below that cover the period of health care from (date) _____ to (date) _____.

Type of Information to be Released

☐ My complete health record, OR

☐ **Only** the following information:

☐ Diagnosis & treatment codes	☐ Discharge summary	☐ History & physical exam
☐ Consultation reports	☐ Progress Notes	☐ MRI reports
☐ X-ray reports	☐ CT reports	
☐ Other, specify: _____		

I understand that my health record may include information about mental health diagnosis or treatment; alcohol, drug, and/or controlled substance abuse, diagnosis, or treatment; or HIV/AIDS diagnosis or treatment. **Only initial one on each line below:**

I do _____ /do not ____ authorize the release of information pertaining to mental health.

I do _____ /do not ____ authorize the release of information pertaining to alcohol or drug abuse.

I do _____ /do not ____ authorize the release of information pertaining to HIV/AIDS.

Purpose of the Requested Disclosure

I am authorizing the release of my Protected Health Information for the following purposes:

☐Medical Care ☐Insurance ☐At the request of patient
☐Other (specify)_____

Time Period for this Authorization

This Authorization will expire on the following date, event or condition _____, or within one (1) year of the below date of this Authorization, whichever occurs first.

Revocation of This Authorization

I understand that I have the right to revoke this Authorization at any time to prohibit future release of my information. To revoke this Authorization, I must send written notice to Cypress Pointe Pain Management, to the attention of the office manager, at the address indicated above. I understand that my revocation of this Authorization applies to future disclosures only and will not have any effect on any disclosures of Protected Health Information made before receiving the revocation.

Redisclosure

I understand that my Protected Health Information disclosed pursuant to this Authorization may be redisclosed by the recipient identified above, and may no longer be protected from disclosure to others by federal or state law.

Waiver

I hereby expressly waive any claim of privilege or privacy with respect to the released information. I release and forever discharge Cypress Pointe Pain Management and its agents, servants, or employees from all liability or claims, of any kind or character, in any way arising out of the disclosure of the requested information, including disclosures made in good faith.

Voluntary

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Signature of Patient/Patient's Representative: **Date:**

_____ _____

Print Name of Patient's Representative: **Relationship to Patient:**

_____ _____