St. Luke's Medical Group

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:

Full Name ____________________ Date of Birth ____________________

Information regarding health care provider/entity authorized to disclose this information:

Name ____

Address ____________________ City ____________________

State ____________________ Zip Code ____________________

Phone ____________________ Fax ____________________

Information regarding health care provider/entity who can receive and use this information:

Alberto Cuellar, MD
2255 East Mossy Oaks, Ste. 320
Spring, TX 77389
Ph: 832.534.7860 Fax: 936-266-8580

Specific information to be disclosed:

( ) Medical record from (date) ____________________to (date) ____________________

( ) Complete medical record **( )** Progress notes **( )** Pathology report **( )** Laboratory tests **( )** Radiology reports

Other (please specify)

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The individual signing this form agrees and acknowledges as follows:

(i) This authorization is voluntary and CHI St. Luke's Health may not condition treatment upon obtaining this authorization

(ii) This authorization shall be in effect until two (2) years after the death of patient for whom this authorization is made or the following specified date : Month ____________ Day____________ Year ____________

(iii) I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken. I understand the revocation must be in writing.

(iv) This authorization may include information relating to **DRUG, ALCOHOL, SUBSTANCE ABUSE, MENTAL HEALTH** and **CONFIDENTIAL HIV/AIDS REALATED INFORMATION**.

(v) A photocopy or fax of this authorization is as valid as the original.

(vi) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

SIGNATURES:

Patient/Legal Representative ____________________ Date ____________________

If Legal Representative, relationship to patient ____________________