CYPRESS CREEK HOSPITAL

17750 Cali Drive Houston, Texas 77090 Phone: 281-586-7600 Fax: 281-586-5923

Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request

Please read this entire form. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. Authorization may not be required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **COPIES WILL BE SUBJECT TO A REASONABLE FEE AS PROVIDED BY STATE LAW**

Patient Name: ____ **Date of Birth**: ___/____/_____

Address: _____________________________________ **City:** ______________________ **State**: ______ **Zip:** ______________

Phone: ____________________________________ **Last 4 of Social Security Number:** ___________

☐ The said patient above has **declined** to complete this form.

I hereby freely and voluntarily authorize Cypress Creek Hospital to ☐ **RELEASE** ☐**OBTAIN** the following ☐ **TO** ☐**FROM**

(Mark only One box) ***(Mark only One box)***

☐ Self (Same address as above- no need to rewrite)

Recipient Name: ____**Relationship**:___________________________________

Address: _____________________________________ **City:** ______________________ **State**: ______ **Zip:** ________________

Phone: ___________________________________**Fax (healthcare provider only):** ______________________________________

Preferred Delivery Method: ☐ Fax ☐ Mail ☐ Email ____

Purpose of Disclosure: ☐ Continuum of care ☐ Personal Use ☐ Legal ☐ Other (specify):___________________________

Covering the period of healthcare from: Specific Date(s): ____________________ to _________________

The information to be released or obtained includes:

☐ Discharge Summary
☐ Discharge Instructions
☐ Psychiatric Evaluation
☐ History and Physical
☐ Treatment Plan
☐ Laboratory Reports
☐ Physician Orders
☐ Other (specify):_______________________

☐**Substance Use Disorder (SUD)** Treatment Records If you are authorizing the release of Substance Use Disorders (SUD) treatment information, please read and sign below. I understand that by selecting the option to release my SUD treatment records, I am authorizing Cypress Creek Hospital to disclose information related to my SUD diagnosis, treatment, progress, medications, and any other SUD-related documentation. **I authorize disclosure of all of my substance use disorder information (patient initials required in box)** ☐

I have read this form and agree to the uses and disclosures of the information as described. I understand that my medical records may include information regarding diagnosis and treatment of **DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology), or PSYCHIATRIC DISORDERS**. I understand that such information is confidential and is protected by federal law. I understand that refusing to sign this form does not stop disclosure of health information that already has occurred or that is otherwise permitted by law without my specific permission, including disclosures as provided by Texas Health & Safety Code § 181.154(c), 45 C.F.R. § 164.502(a)(1), and/or 45 C.F.R. 164.512(a). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient (unless re-disclosure is prohibited by law) and may no longer be protected by federal or state privacy laws. I understand that I may inspect or copy any information to be used or disclosed under this authorization.

____

Signature of Patient or Personal Representative **Date**

____

Printed Name of Parent, Guardian, Authorized Representative (if applicable) **Date**

____

Printed Name of Witness **Signature of Witness** **Date**

To **revoke** this authorization, sign and date in the space provided below. By signing this revocation, I understand that this revocation will be effective today, except to the extent that CYPRESS CREEK HOSPITAL has already relied upon by authorization to use or disclose my health information as described in the Notice of Privacy Practices.

Signature ____ **Date:** ____________**Witness:** _________________________________**Date:** _________