COMMUNITY HEALTH NETWORK

INCOMING

Call Center: 281-824-1480
Medical Records Fax #: 281-220-6442
www.sfachn.org

Patient Authorization for Use or Disclosure of Protected Health Information (PHI)

HIPAA Privacy Authorization to Request Medical Records

Part: 1. Patient Information

Patient Name: _____

Address: _____ DOB: _____

Part: 2. Use and Disclosure of Health Information

I hereby request and authorize: _____

Phone Number: _____ Fax Number: _____

to disclose (release) my PHI to:

- Stephen F. Austin Community Health Center, Inc., dba
  COMMUNITY HEALTH NETWORK
  1111 W. Adoue Street Alvin, TX. 77511
  Telephone: 281-824-1480
  Fax: 281-220-6442

Part: 3. This Authorization Applies to the Following Information:

I AUTHORIZE THE FOLLOWING RECORDS TO BE RELEASED:

☐ All Health Information pertaining to my medical history or physical condition and treatment received, with the exception of psychotherapy and substance use disorder notes (as that term is defined in 45 C.F.R. § 164.501)

☐ Only the following types of Health Information (specify and include dates):

_____

*I specifically authorize the disclosure or release of the following information (check as appropriate):

☐ Mental/Behavioral Health Records

☐ Dental Records (treatment plans, x-rays, etc.)

☐ HIV/AIDS and STD Information

☐ Itemized Billing Statement

☐ Alcohol and/or drug abuse/chemical dependency treatment information.

Part: 4. Notice of Patient Rights Regarding Authorization

By signing this Authorization form, I understand that I am giving my authorization for CHN to receive all protected health information (PHI) relating to my diagnosis, testing or treatment. I understand that my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. I may revoke this authorization at any time by notifying CHN in writing to the Medical Records Department.

Part: 5. Signature

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Printed Name of Patient or Authorized Representative | Relationship to Patient

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST WILL NOT BE PROCESSED. *Authorization automatically expires 180-days after signing.*

Revised on 3/18, 5/18, 11/18