COMMUNITY HEALTH NETWORK

OUTGOING

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 Release Medical Records

Part: 1. Patient Information

Patient Name: _____

Address: _____ DOB: _____

Part: 2. Use and Disclosure of Health Information

I hereby request and authorize: Stephen F. Austin Community Health Center, Inc., dba **COMMUNITY HEALTH NETWORK**

to disclose (release) my PHI to:

- Name of Person/Organization: _____
- Phone Number: _____ Fax Number: _____
- Address: _____
- City: _____ State: _____ Zip: _____

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

I AUTHORIZE CHN THE USE AND/OR DISCLOSURE OF THE FOLLOWING RECORDS:

□ 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 ☐ HIV/AIDS and STD Information.

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

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

Part: 4. Notice of Patient Rights Regarding Authorization

By signing this Authorization form, I understand that I am giving my authorization for CHN to release 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 3/18, 5/18, 11/18