

CEDAR CREST CLINIC
3106 S. WS Young Drive, Suite B-201
KILLEEN, TX 76542
Phone 254-519-4162 / Fax 254-519-3464

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

Person/Entity: _____
 Address: _____
 City, State, Zip Code: _____
 Telephone/Fax: _____

To release to:

Person/Entity: _____
 Address: _____
 City, State, Zip Code: _____
 Telephone/Fax: _____

medical records obtained during the course of treatment of:

Patient Name: _____
 Date of Birth: _____
 Social Security Number: _____
 Dates of Treatment: _____

Disclosure is necessary for the purpose of _____ and that purpose only. I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. The information to be released includes (please check records to be disclosed pursuant to this Authorization):

- | | | |
|--|---|---|
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Therapist Progress Notes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Initial Evaluation | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Admission Notes | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> Mental Status Exam | <input type="checkbox"/> Verbal Communication with: |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Medication Records | Name: _____ |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Laboratory Data | Relationship: _____ |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Consultation Reports | _____ |

The treatment dates covered by this Authorization are from initial outpatient visit to the present including claims resolution, and from pre-admission to discharge including claims resolution. I understand that information used or disclosed under this Authorization may be subject to redisclosure by the recipient without being further protected under federal and state privacy regulations. I understand that I have the right to refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment.

I hereby release Cedar Crest from all legal responsibilities or liability that may arise from disclosure of my medical records in reliance on this Authorization.

I understand that I have the right to revoke this Authorization at any time, except to the extent that action has been taken in reliance on this Authorization. To revoke this Authorization, I must provide a written notice of my intent to revoke along with the date and purpose of this Authorization. This revocation statement must be signed by me and delivered to the facility where I gave my authorization. The revocation will be effective the date it is received by the facility.

I understand that I have the right to receive a copy of this Authorization. I understand that I have the right to inspect the information to be disclosed upon proper notification to, and under appropriate conditions established by, Cedar Crest. This Authorization will automatically expire 60 days from the date of my signature. If patient is a minor, the parent/guardian must sign the Authorization.

_____ Date	_____ Patient	_____ Date	_____ Parent/Guardian
_____ Date	_____ Staff Member/Witness Signature	_____ Guardian's relationship to Patient	