Katy Trail Community Health

Patient's Full Name	Phone #	Date of Birth	SSN:
_____	_____	_____/_____/_____	_____

I authorize Katy Trail Community Health to (check one):

□ Release/Disclose Records to
□ Obtain Records from

Name/Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

The following information is for treatment received from:	_____ **to** _____

This authorization applies to the below services (check all that apply):

□ Medical □ Dental □ Mental Health (includes Psychiatry and Behavioral Health)

Information to be released- specific to treatment dates & service checked above (check all that apply):

□ All records (visit notes, labs, diagnostics)	□ Laboratory Test results
□ Provider Visit Notes	□ Diagnostic Results
□ Visit Summaries	□ Immunization (shot) records
□ Nursing Notes	□ Billing Records
□ Face Sheet- Summary with your diagnoses, medications & contact information	□ Other: _____

Purpose/Reason for disclosure (Check all that apply):

□ Continuation of Care □ Personal Records □ Insurance Reasons □ Legal Reasons □ Other, specify: _____

I understand that my medical, dental, mental health and billing information may include information in reference to drug and/or alcohol abuse, CFR 42 Part 2, psychiatric treatment, sexually transmitted disease, Hepatitis C or Hepatitis B testing or treatment and/or HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information. By signing below, I agree to its release, otherwise by initialing and qualifying this clause here I reject the release of these specially protected records: _____

Revocation Process: I understand that I may, by placing my request in writing to Katy Trail Community Health, revoke this authorization at any time, except in the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date of signature.

Redisclosure: I understand that authorizing the disclosure of this protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and information may not be protected by federal privacy standards. If I have questions about disclosure of my protected health information, I can contact the Privacy Officer for Katy Trail Community Health.

Prohibition of Redisclosure: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Copy of Release: If you would like a copy of this release, initial here: _____

Patient's Signature: _____ Date: _____

Signature of Parent/Legal Guardian/Legal Rep: _____ Date: _____

Printed Name of Parent/Legal Guardian/Legal Rep: _____Relationship to Patient: _____

Office Use Only:
Records released by: _____ Date Completed: _____

Centralized Medical Records
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Phone: 660-826-4774
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