HOUSTON HEALTH DEPARTMENT

Authorization for Release of Protected Health Information

Patient's/Client's Name: _____/_____/_____/_____
(Please Print) Last First Middle Maiden/Other Name

Date of Birth: _____/_____/_____ EHR # _____

Contact Number: _____ Other Patient Identifiers: _____

I hereby authorize:

☐La Nueva Casa Health Center ☐Northside Health Center ☐Sharpstown Health Services ☐Sunnyside Health Center
☐ Central Laboratory ☐ Other _____

to release copies of the following Protected Health Information of the above-named patient/client

☐ Dental ☐ Dental X-Rays ☐ Family Planning ☐ Immunizations

☐ Laboratory Only (specify) _____

☐ Sexually Transmitted Disease (STD) ☐ Tuberculosis (TB) ☐ Tuberculosis X-Rays

☐ Other _____

☐ Special Instructions _____

Date of Service/Event or Condition of this request: _____

Purpose of Release: ☐ Personal Use ☐ Continuing Health Care ☐ School ☐ Employment ☐ Legal
☐Military ☐ Insurance ☐ Other (Specify): _____

DELIVERY/FORMAT: ☐ Pick Up ☐ Fax ☐ Mail ☐Encrypted Email
☐ Unencrypted Email **(not recommended)** ☐Electronic: Format _____

RELEASE TO: ☐ **Self**
☐ **Other:** _____
(Name of Physician/Clinic/Hospital/Institution, etc.)
Address: _____
Street City State Zip
Fax Number:_____
Email Address: _____

I understand that this request can be cancelled in writing. Houston Health Department will not be liable for releases made before I cancel this request. I understand that when the information is released based on this request; it may be subject to re-release by the recipient and may no longer be protected health information. I understand that the protected health information indicated above may contain extremely confidential information including Human Immunodeficiency Virus (HIV) and other sexually transmitted diseases (STD) test results unless I indicate otherwise. I understand that this release is valid 180 days. I can indicate an earlier expiration date here: _____.

Patient/Representative_____ **Date**_____

Representative Relationship To Patient _____