gerstenberg.clinic

K. Paul Gerstenberg, D.O. • 2645 Nall Street • Port Neches, Texas 77651 • Phone: 409.210.3336 • Fax: 409.527.3969

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Printed Name: _____ DOB: _____ Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Phone Number: _____

Health care period of information to be released

☐ ALL Dates *OR* ☐ From: (date) _____ To: (date) _____

Information to be released

☐ Complete Health Record ☐ Discharge Summary and Instructions ☐ Radiology reports
☐ Laboratory test results ☐ Office notes, medication history and correspondence ☐ Other (specify) _____

Include (must INITIAL each requesting to be released)

_____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records

_____ HIV/AIDS Related Information (Including HIV/AIDS Test Results) _____ Genetic Information (Including Genetic Test Results)

Purpose of request

☐ At the request of the patient ☐ Treatment/Continuing Medical Care ☐ Other (specify) _____

Method of sending / Release information:

☐ Fax ☐ Paper ☐ CD ☐ Secure Direct eMessaging ☐ Any of Above

I hereby request release of my medical records from:

Provider Name: _____ Provider Phone #: _____

Provider Address: _____ Provider Fax #: _____

To: K. Paul Gerstenberg, D.O., P.A. (gerstenberg.clinic)

2645 Nall Street | Port Neches, Texas 77651 | Fax: 409.527.3969 | Ph: 409.210.3336

The individual signing this form agrees and acknowledges the following

Voluntary Authorization: This authorization is voluntary. Treatment or payment for services will not be conditioned upon my signing of this authorization form.

Right to Revoke and Time Limit: I understand that I have the right to revoke this authorization at any time by submitting a notice in writing to the facility. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Unless revoked, this authorization will expire on the following date or event or 180 days from the date of signature.

Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, CONFIDENTIAL HIV/AIDS RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of the types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Signature: _____ Date: _____

(Patient or Legal Representative - please state relationship)