

# gerstenberg.clinic

2927 Nall Street • Port Neches, Texas 77651 • Phone: 409.210.3336 • Fax: 409.527.3969 • www.gerstenberg.clinic

## 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)

2927 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)

Last revised 06/01/25