PEARLAND
HEALTHCARE CENTER

# Authorization to Disclose Medical Records

| Patient Name: | Date of Birth: |
|---|---|
| | |

I hereby authorize

**Pearland Healthcare Center**
2404 Smith Ranch Rd. Suite 200
Pearland, TX 77584
PH: (713) 436-4333
FX: (844) 322- 8254

To: □ Obtain □ Disclose

My Protected Health Information to/from the following facility/doctor

Facility/Doctor _____

PH: _____

FX: _____

For the purpose of: □ Medical Care □ Legal □ Insurance □ Disability □ Other: _____

Date(s) to be released: _____

Records to be released:

| | |
|---|---|
| □ Labs | □ Entire Record EXCLUDING –HIV testing & Chemical Dependency |
| □Emergency Room | □ Entire Record INCLUDING –HIV testing & Chemical Dependency |
| □Imaging/Radiology | □ Entire Record INCLUDING –HIV testing only |
| □ MD Progress Notes | □ Entire Record INCLUDING –Chemical Dependency |

□ Other: _____

*This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of the above listed facility to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____

Signature of Patient/Parent/Conservator/Guardian | Authority/Relationship to Patient | Date