Health Center of Southeast Texas

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Cleveland, Texas 77327	Shepherd, Texas 77371	Liberty, Texas 77575	Livingston, Texas 77351
(P) 281-592-2224	(P) 936-628-1100	(P) 936-334-1185	(P) 936-327-4660
(F) 281-592-2225	(F) 936-628-1188	(F) 936-391-3000	(F) 936-327-4661

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Patient's Address: _____ City: _____ State: ____ ZIP Code: _____

Birth date: _____ Social Security Number: _____

Records Released From:

Physician's Name: _____

Street Address: _____

Phone Number: _____ Fax: _____

Release Records To: SELF ☐

Physician's Name: _____

Street Address: _____

Phone Number: _____ Fax: _____

Purpose or need for the information requested: Continued Care _____ *Insurance* _____ *Legal* _____
Transfer _____ *Personal* _____

☐ All records ☐ Most recent lab reports/x-ray reports ☐ Billing records ☐ Other (specify)
_____.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is sued for disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will NOT be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

I hereby authorize the release of all necessary medical records to **HCSET.**
I wish for them to be forwarded as soon as possible.

Patient's (Parent's) Signature: _____ Date: _____
(**Or parent if patient is a minor)**
Signature of Witness: _____