

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I HEREBY AUTHORIZE

\_\_\_\_\_  
Name of Doctor / Facility

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Phone Number Fax Number

To disclose the below named individual's health information to:

**YOUENS AND DUCHICELA CLINIC**  
Dr. Jorge Duchicela Dr. Olga Duchicela  
402 Youens Drive  
Weimar, Texas 78962

Tel: 979-725-8545

Fax: 979-725-8287

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated below and any other use of this information without the consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire on the following date, event or condition: \_\_\_\_\_

If I fail to specify an expiration date, event or condition this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager.

Reason for Disclosure

Please release the following:

For Dates:

To:

- Continuation of Care
- Billing / Claims
- Insurance
- Legal Purposes
- Other: \_\_\_\_\_

- Complete Chart
- Progress Notes / H&P
- Medication List
- Immunization Record
- Xray / Imaging Reports
- Laboratory Results
- EKG Reports
- Other (Specify) \_\_\_\_\_

\_\_\_\_\_  
Patient Name Date of Birth Social Security #

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Patient / Parent of Minor / Guardian Signature Date