# AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

| Patient's Last Name: | Patient's First Name: |
|---|---|
| Date of Birth: | Phone Number: |
| Address: | City, State, Zip: |

I authorize CapRock Health/Caprock Emergency Physicians PA to RELEASE information to:

Name: ________________________________________________

Address: ________________________________________________

Office Phone / Fax: ________________________________________________

I hereby authorize the use or disclosure of Protected Health Information as described below for the following DATE(s) of SERVICE:

__________ - __________

| | | |
|---|---|---|
| ☐ Complete Health Record<br>☐ Assessments<br>☐ History / Physical Exam<br>☐ Progress Notes<br>☐ Discharge Summary | ☐ Treatment Plans<br>☐ Treatment Summary<br>☐ Diagnostic Impression | ☐ Laboratory Report<br>☐ CT Report<br>☐ CT Images<br>☐ X-Ray Report<br>☐ X-Ray Images |

Purpose of Disclosure: ☐ Healthcare ☐ Insurance ☐ Personal ☐ Attorney/Litigation ☐ District Attorney ☐ Other:

One-Time Use / Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. Authorization expires:

☐ When the requested information has been sent / received

☐ 90 days from this date ☐ Other:

Periodic Use / Disclosure: I authorize the periodic use or disclosure of the information described above to the person /provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document

Authorization Expiration:

☐ When I am no longer receiving services from the provider/facility/organization listed above.

☐ One year from this date

☐ Other:

I UNDERSTAND that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to CapRock Health/Caprock Emergency Physicians PA, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of the facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be-disclosed
- If the authorized information is protected by the Federal Confidentiality Rules 42FCR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV / AIDS related information requires additional information
- Communicable diseases including any Texas Notifiable Conditions and other communicable diseases which may pose a threat to the general public, required by TDSHS, CDC or any regulatory agency may be released with or without my permission.
- If the medical record information is not sent to another care provider, there may be a change for the requested records.

If you are the Patient Representative, check the scope of your authority to act on patient's behalf:

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor or Personal Representative ☐ Other:

**Signatures: I have read the above and authorize the disclosure of the Protected Health Information as stated:**

Signature of Patient (or Patient's Representative): ______________________Date: __________

Printed Name of Patient (or Patient's Representative): ______________________Date: __________

***CapRock Health Office USE ONLY*** ☐ *Copy of Identification Attached and Verified – Additional ID may be required at the request of the facility. (* Picture Identification MUST be provided prior to "Release of Information".)*

*Signature of Person Releasing Information:* ______________________________

*CapRock Health Employee Signature*