Katy Psychiatry
Marco A. Reñazco, MD, PA
24215 Kingsland Boulevard
Katy, TX 77494
Office: 281-599-3313 Fax: 832-437-1132

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____

Patient's Name *(print)* | Date of Birth | Social Security No.

_____

Street Address | City | State | Zip Code

do hereby authorize the use and/or disclosure of my protected health information

AUTHORIZED ENTITY

I request to have my health information released ☐ from ☐ to the following entity *(check one)*:

_____

Name

_____

Street Address | City | State | Zip Code

_____

Phone Number | Fax Number

AUTHORIZED PROTECTED HEALTH INFORMATION *(all record excluding billing and insurance information)*

- ☐ Mental / Behavioral Health Records of Care from _____ to _____
- ☐ Medical Records *(Non-Mental / Behavioral Health Record)*
- ☐ Discharge Summary
- ☐ Lab Results from _____ to _____
- ☐ Radiology Results from _____ to _____
- ☐ Other / Specify: _____
- ☐ HIV / AIDS related record *(Except HIV Test Results)*

I understand that the release of health records may involve making available to me or to others information of a personal nature issues such as: the use of cigarettes, alcohol, and other drugs, as well as possible exposure to infectious disease, may be part of the mental health record.

PURPOSE OF DISCLOSURE: ☐ Health Care ☐ Employer ☐ Attorney ☐ Insurance ☐ Other: _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. I hereby acknowledge that this consent is truly voluntary and valid until revoked, and that I may revoke this consent at any time, in writing, except to the extent that action based on this consent has been taken. I further understand that this authorization will expire in 1 year from the date of signature unless otherwise specified _____ *(Expiration Date)*.

_____

Signature of Patient / Legal Guardian / or Medical Power of Attorney | Date | Printed Name of Patient's Legal Guardian or Medical Power of Attorney *(if applicable)*