Authorization to Use or Disclose Protected Health Information

Patient Name: _____ DOB: _____

This form will authorize the below facility to provide a copy or summary of my medical records to **Elevate Health Clinics** as indicated on this authorization:

Facility name where records are located: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records to be released include:

____ **Records** for the period of _____ through _____

____ **Lab Results –** Date(s): _____

____ **MRI results/X-ray –** Date(s): _____ Type: _____

____ **Other**: _____

The above information may be released to:

Elevate Health Clinics
712 N Washington Ave
Dallas, TX 75246

Phone: 855.435.3828
Fax: 214.377.5022

Expiration of authorization (you must specify a date or event, i.e. at the end of litigation)**:** _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed above and no longer protected. I have the right to revoke this authorization in writing except to the point that action has already been taken in reliance upon the authorization. I also understand that treatment or payment cannot be conditioned on the authorization.

Signature (Patient/Guardian): _____ Date: _____