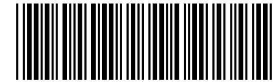
NORTH CYPRESS MEDICAL CENTER
AUTHORIZATION FOR RELEASE OF INFORMATION



HIMARP1

North Cypress Medical Center Is A Doctor Owned, Patient Centered Healthcare Institution.

Patient Last Name	First Name	Date of Birth

My health information may be released to:

Name of Recipient:			
Address:			Telephone Number:
City:	State:	Zip:	Fax Number:

Purpose of the Disclosure:

❑ Continued Care ❑ Attorney/Litigation ❑ Insurance ❑ Disability Services ❑ Other:____________________

I hereby authorize the use or disclosure of protected health information as described below.

Date(s) of service:____________________

❑ Discharge summary
❑ History/Physical Exam
❑ Consultation Reports
❑ Other: ____________________

❑ Emergency Department Records
❑ Operative Reports
❑ Cardiology Reports

❑ Pathology Reports
❑ Laboratory Reports
❑ Radiology Reports

❑ All Pertinent Records for Continued Care
❑ Radiology Image/CD
MD Anderson ❑
TX Children's ❑

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires within 60 days. Otherwise, you may select either of the following expiration events:

❑ 1 year from the date in which I, or my legal representative signs this authorization
❑ Upon the happening of the following event: ____________________
(Example: "Upon release of the above records")

I understand that:

1. I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care.
2. My revocation will not have any affect on any actions taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.
3. The organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.
4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

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**

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Print Name of Patient (or Patient's Representative)

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

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

Return to:
Health Information Management
North Cypress Medical Center
21214 Northwest Freeway
Cypress, Texas 77429

Phone: 832–912–3530
Fax: 832–912–3778

Adm:
Attending:

Rev. 06/15