St. Michael Medical Clinic

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12609 Louetta Road ◆ Cypress, Texas 77429 ◆ Phone: 281-655-5100 ◆ eFax: 888-990-2119 ◆ Fax: 281-655-1415

Authorization for Release of Protected Confidential Health Information

Patient (Last, First) _____ DOB(mdy): _____

I authorize **St. Michael Medical Clinic, P.A.** ☐ to release to ☐ receive from

Doctor Name / Organization: _____

Address: _____

Phone: _____ Fax: _____

information and records regarding my treatment, medical and/or behavioral health conditions.

Information to be released or exchanged includes (check all that applies): ☐ Entire Chart (not including billing)

☐ History & Physical	☐ Discharge/Consultation Summary	☐ Behavioral Health
☐ Laboratory Reports	☐ Medication Records	☐ HIV or Communicable Diseases
☐ Diagnostic Testing	☐ Immunization Records	☐ Other _____

_____

I understand that I may revoke this authorization in writing at any time, except to the extent that caption has been taken in alliance on it and that in any event that authorization shall expire (365) days from the date of my signature, unless specified in writing. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider; the release information may no longer be protected by federal or state privacy regulations.

Patient/Guarantor Signature: _____ Date: _____

In about 1-2 weeks, we ask patient to call us @ 281-655-5100 to check if we received the MR.

Please include this Authorization form when sending MR information back to St Michael Medical Clinic efax 888-990-2119.

If more than 10pages, please do not fax, send on CD
or PLEASE email MR **to STMICHAELCLINIC@myupdox.com**

TO THE RECEIVING PARTY: This information has been disclosed to you from records whose confidentially may be protected by Federal Law. If so, federal regulations prohibit you from making any, without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general further disclosure of it authorization for the release of information is not sufficient for this purpose. This message is intended only for the use of the individual to whom, or entity to which is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you have received this communication in error, please notify us immediately by phone. 201604

Instruction for Staff:

1. SMMC Staff fax-out and enter message into AzC using template "Release MR". Save to Pt Chart.
2. Filed Auth Release MR form with prgnotes folder dated: _____ BY: _____