FORM 1021 - AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification - Please Print

Full Name: _____ Date of Birth: _____/_____/_____

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____/_____/_____ Home Telephone #: _____

Information To Be Released - Covering the Periods of Healthcare

From: _____

_____

_____

_____

(Name, Address and Phone)

Date Range: _____

Type of Information To Be Released - Please Circle Only Those That Apply

Complete Health Record	Photographs, Videotapes	X-Ray Report	Progress Notes
History and Physical exam	Diagnosis and Treatment Codes	Complete Billing Records	X-Ray Films/Images
Laboratory Test Results	Consultation Report	Discharge Summary	Itemized Bill

Other, (please be specific): _____

Purpose of Request

Treatment or Consultation At the Request of the Patient Billing or Claims Payment

Other (please be specific): _____

Who and Where to Send/Release Information

To: _____

_____

_____

_____

(Name, Address and Phone)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

Initial One:

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and treatment, that I have been afforded the opportunity to sign a specific authorization. Yes No Not Applicable

I understand if my medical or billing records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, that I have been afforded the opportunity to sigh a specific authorization. Yes No Not Applicable

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on the authorization, I can at any time, revoke this authorization by submitting a notice in writing to the Privacy Officer at EBM and Associates, 11830 FM 1960 rd West, Houston, TX 77065. Unless revoked, this authorization will expire on the following date or event _____, or 180 days from the date of signature.

Re-Disclosure

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and o longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose fo Request. I can inspect or copy the protected health information to be unsed or disclosed. I authorize the release of this information to EBM and Associates, Dba Cypress Lakewood Clinic, which may need the information for treatment, payment or healthcare operation.

I authorize EBM and Associates, DBA Cypress Lakewood Clinic to release the protected health information specified above.

Signature: _____ Date: _____

Signing Authority (if not patient): _____ Relationship: _____

Identity of Requestor Verified via: Photo ID Matching Signature Other (specify): _____

Verified by: _____ Printed Name: _____