M.Cristina Ivan, M.D., P.A.

3355 West Alabama, Suite 1180

Houston, TX 77098

(713) 942-0538

**Authorization to Use/Disclose Health Care Information**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maiden or other name** (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release the health care information described below to:

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City, State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method of delivery (if fax, specify number):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This request and authorization applies to only the following protected health information:**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_ HISTORY / PHYSICAL EXAM | \_\_\_\_\_ LABORATORY REPORTS | \_\_\_\_\_\_ CONSULTATIONS |
| \_\_\_\_DISCHARGE SUMMARY | \_\_\_\_\_ DOCTOR’S ORDERS | \_\_\_\_\_\_ PROGRESS NOTES |
| \_\_\_\_PSYCHIATRIC REPORTS / TESTS | \_\_\_\_\_ PSYCHOLOGICAL REPORTS \_\_\_\_\_\_BILLING RECORDS | |

\_\_\_\_INITIAL PSYCHIATRIC EVALUATION \_\_\_\_\_ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**during the following time period or dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug M.Cristina Ivan, M.D., P.A.

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abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Purpose(s) of this use/disclosure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date or event)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to M. Cristina Ivan, M.D.

I understand that Dr. Ivan may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

**Signature** (patient or authorized representative)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (if signed by authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_