HealthPOINT
A DBA of Brazos Valley Community Action Agency, Inc.

I AUTHORIZE HEALTHPOINT (DBA BVCAA) TO RELEASE MEDICAL RECORDS INFORMATION

PROVIDE THE PATIENT'S INFORMATION:

Name: _____ **Date of Birth:** _____

Email: _____ **Phone:** _____

HOW WILL WE RELEASE THE INFORMATION (SELECT ONE OPTION)

☐ By Secure Email to Download Records (1–2-day delivery)
☐ By Mail* (7–14 days delivery, dependent upon USPS)
☐ By Fax

**Records exceeding 60 pages will be charged a fee of $15.00.*

WHO WE WILL RELEASE THE INFORMATION TO (SELECT ONE OPTION)

Name/Organization: _____

☐ Send Email Link To: _____ ☐ Fax To: _____

☐ Mail To This Address: _____

City: _____ **ST:** _____ **Zip Code:** _____

Dates of Service (Check One and Complete Dates of Service if Required)

☐ Please provide a complete copy of my file for service from _____ through _____

Records to be Released (45 CFR § 164.508(c)).

☐ Entire Chart
☐ Radiology Reports
☐ Immunizations
☐ Itemized Billing
☐ Office Notes
☐ Radiology Images
☐ Operative Reports
☐ Lab Reports
☐ Consults
☐ Medications
☐ Physical Therapy
☐ Other _____
☐ Behavioral Health / Substance Use Disorder Records

_____
Initial

I understand that the records I have authorized for release may include information related to the diagnosis or treatment of a substance use disorder or behavioral health condition that is specially protected under federal law (42 CFR Part 2). By initialing here, I specifically consent to the release of these protected records. I understand that once this information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by 42 CFR Part 2.

Purpose for Disclosure

☐ Continuing Care
☐ Transfer of Care
☐ Referring Physician
☐ Disability
☐ Legal/Attorney
☐ Insurance
☐ Other _____

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Signature:

Printed Name of Patient:

Relationship to Patient (if not the patient):

Date:

Reason if patient is unable to sign:

(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request.)