Patient – Access and Authorization for Disclosure of Protected Health Information (PHI) HIPAA Release

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: _____ Birthdate: _____

Address: _____

PURPOSE OF DISCLOSURE: Continued Care

FACILITY VISITED: HISD On-Site Clinics

Records to be disclosed related to the following date(s) of service _____

■ Complete medical record □ Lab Results □ Physician Orders □ Prescriptions □ Itemized Bill □ X-ray
□ Other: _____

CONFIRMATION OF WHO MAY RECEIVE COPIES OF YOUR RECORDS

Person/Entity Name: Next Level Urgent Care

Address: 5749 San Felipe City: Houston St: TX Zip: 77057

Fax Number: _____ Confirmation Phone Number: _____ Email: medicalrecords@nextlevelurgentcare.com

BY: □ Mail □ Call at number to pick up □ Fax ■ Email

IN CONNECTION WITH THIS AUTHORIZATION

- The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficient Syndrome (AIDS). To authorize disclosure of **any of the following sensitive information initial the applicable line(s) below**:
  ___ Alcohol / Drug Abuse Treatment / Referral ___HIV/AIDS-related Testing and/or Treatment
  ___Sexually Transmitted Diseases ___Mental Health (Other than Psychotherapy notes)
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.
- I understand that this authorization expires one year from date of authorization, unless revoked or a shorter duration is specified here_____. Additionally, applicable State Law may specify a shorter duration.
- I have a right to receive a copy of this authorization.

Patient's Signature / Date: _____ or Signature of Patient's Representative / Date: _____

Printed Name of Patient's Representative Explanation of your legal right to sign for Patient

For HIPAA questions related to this form, please contact the Privacy Office at 1-800-819-5571.

Facility please complete below and email with copy of records to PrivacyOffice@Concentra.com or fax to 214.775.4408:
□ Date request received: _____ □ Date sent to Privacy Office: _____ □ Approved □ Denied (reason)_____