New Horizon Health Center

Authorization to Request and/or Release Protected Health Information (PHI)

Individual/Patient (Name & Information of person whose protected health information is being disclosed).

Name | Date of Birth

Address (City, State, ZIP Code) | Telephone #

I request to have the information released ☐TO /☐ FROM :

New Horizon Health Center | 191 E. Price Rd, Brownsville, TX 78521

Telephone: (956) 548-7400 | Fax: (956) 621-3689

I request to have the information released ☐TO / ☐FROM :

_____ | _____

Name of Facility/Physician | Phone Number

_____ | _____

Address (City, State, ZIP Code) | Fax Number

Purpose(s) (You must check at least one box below).

☐ Legal/Attorney Request
☐ Continuing care or treatment / Specialist referral
☐ Other – Please describe:

_____

☐ Insurance
☐ Personal Use
☐ Application for federal, state, or local services

Description of Information to be Disclosed

☐ Complete medical record (includes labs and immunizations)
☐ Specific date(s) of services: _____
☐ Behavioral Health records (Psychiatric)
☐ Special Request:

_____

☐ Lab Results only
☐ Physical/Well-child check only
☐ Immunizations only

I know that my written consent is needed to release any protected health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, genetic testing, psychiatric disorders, mental health, or drug or alcohol abuse. If I have been tested, diagnosed, or treated for any of the above named conditions, you are authorized to release health care information relating to such diagnosis testing, or treatments. _____ Patient's Initials

My permission is only in force until the following date or event: _____

I know that I have the right to withdraw this authorization, in writing, at any time by sending such written notice to the NHHC Health Information Management Department or Compliance Officer. I understand that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I also know that information used or disclosed before this authorization may be subject to re-disclosure by the person who received the information and may no longer be protected by state or federal law. **This authorization will expire one year from date signed unless otherwise noted.**

Signature of patient or Legal Representative | **Date** | **Witness** (NHHC Employee)

_____

Print Name of Patient or Legal Representative | Relationship to Patient