AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, _____, hereby authorize:
[PRINT PATIENT NAME] [DOB]

Helical Health, PLLC
8845 Davis Blvd, Ste 100
Keller, TX 76248

817.900.9525 Phone
817.900.9545 Fax

☐ To obtain a copy of records FROM:
☐ To release a copy of records TO:

For office use only:
NPI: _____

[PRINT NAME OF OUTSIDE FACILITY/DOCTOR/MEDICAL PROVIDER]:

Name: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

To include the following health information:
- ☐ All records
- ☐ Partial records: _____

- I authorize the disclosure of the following types of highly sensitive information: __ drug and alcohol; __ mental health (psychiatric); __ HIV/AIDS testing and treatment; __ Sexually transmitted disease; __ Genetic testing
- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose of patient care.
- I understand that the information used or disclosed may be subject to re-disclosure by the facility receiving it and would then no longer be protected by federal privacy regulations.
- This authorization is in effect until revoked. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily. Treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Print Name of Patient/Legal Guardian Relationship to Patient