La Esperanza Clinic

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize La Esperanza Clinic (LEC) to (**select one**)

◯ **release** protected health information

◯ **obtain** protected health information

Patient Full Name _____ Other names used (if applicable) _____

Telephone Number _____ Date of Birth _____

Facility Information:

Name: _____

Address: _____

_____

Fax#: _____

Return address:

La Esperanza Clinic

34 Buick St

San Angelo, TX 76901

Telephone #/Fax # (325)658-5339 / (325)486-8754

Records to be released/obtained (**select one**):

◯ Complete medical records(includes labs and immunizations)

◯ Specific date(s) of services (if not requesting entire chart): _____

Information to be released/obtained (**mark all that apply**):

☐ Chart Notes ☐ Lab Results ☐ Immunization Records ☐ Radiology

☐ Prenatal Care ☐ Dental ☐ Other:

Sensitive information (initials required to release):

☐ Behavioral Health Records _____ ☐ STI Information _____ ☐ Genetic Information _____

☐ AIDS/HIV Information _____ ☐ Substance Abuse Records _____

Purpose for release:

◯ Transfer of Patient Care ◯ Personal Use ◯ Attorney/Legal ◯ Insurance ◯ Other: _____

Notice to Recipient (Applicable Only When SUD Information Is Included):
If the information released includes substance use disorder (SUD) treatment records, it is protected by federal confidentiality rules (42 CFR Part 2). These rules prohibit any further disclosure of SUD information without the patient's specific written consent or unless otherwise permitted by this rule. 42 CFR part 2 prohibits unauthorized use or disclosure of these medical records.

By signing this form, I release La Esperanza Clinic, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the information identified for release. I understand that once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not then be protected by federal & state privacy regulations. I may **revoke** this authorization at any time by providing a written statement to the Health Information Management Dept., except to the extent that LEC or other organization has already completed action on it.

Printed Name of Patient/Legally Authorized Representative _____ Relationship to Patient _____

Signature of Patient/Legally Authorized Representative _____ Date (required) _____

Identity of Requestor Verified via: ( ) Photo ID ( ) Matching Signature ( ) other, specify: _____

Verified By: _____