



North Cypress Medical Center  
21214 Northwest Freeway  
Cypress, Texas 77429  
832-912-3500

# NORTH CYPRESS MEDICAL CENTER

## Authorization for Release of Information

\* HI MARP1 \*

<b>Section A: This section must be completed for all Authorizations</b>		
Patient Last Name	First Name	MI
Date of Birth	Social Security Number (optional)	

**My health information may be released to:**

Name of recipient:			
Address:		Telephone Number:	
City:	State:	Zip:	Fax Number:

**Purpose of the Disclosure:**  
 Continued Care  
 Attorney/Litigation  
 Insurance  
 Disability Services  
 Other: \_\_\_\_\_

**I hereby authorize the use or disclosure of protected health information as described below.**

For the following date(s) of service:

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Emergency Department Records	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Report	<input type="checkbox"/>
<input type="checkbox"/> History/physical exam	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Cardiology Reports	<input type="checkbox"/>
<input type="checkbox"/> Other: _____			

**Expiration:** If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires within 60 days. Otherwise, you may select either of the following expiration events:

1 year from the date in which I, or my legal representative signs this authorization  
 Upon the happening of the following event: \_\_\_\_\_  
(Example: "Upon release of the above records")

- I understand that:**
- I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care.
  - My revocation will not have any affect on any actions taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.
  - The organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.
  - I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

**Signatures: I have read the above and authorize the disclosure of the protected health information as stated.**

Signature of Patient (or Patient's Representative)	Date
Print Name of Patient (or Patient's Representative)	

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

Power of Attorney       Legal Guardian  
 Executor or Personal Representative       Parent       Other: \_\_\_\_\_

**Return to:**  
Health Information Management      **Phone: 832-912- 3530**  
North Cypress Medical Center      **FAX: 832-912- 3778**  
21214 Northwest Freeway  
Cypress, Texas 77429       Please return via Fax

