VECINO
HEALTH CENTERS™

Authorization For the Use and Disclosure of Protected Health Information

Name of Patient or Individual: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Alternate Phone: _____

Email (optional): _____

I authorize the following clinic and/or its administrative and clinical staff

_____
Name of entity and person releasing information

_____
Address of entity or persons releasing information

to (check all that apply):

□ use the following protected health information, and/or
□ disclose the following protected health information to:

_____ _____
Name of recipient (entity or persons) to receive information Phone Number

_____
Address of recipient (entity or persons) to receive information

□ Via mail to address provided above.

□ Via fax to _____

Describe the information to be used or disclosed, including the date of service, type of service, exact level of details to be released, origin of the information, etc., if known:

_____

_____

_____

_____

_____

_____

_____

Drug and Alcohol Abuse, and/or Psychiatric, and/or Psychotherapy, and/or HIV/AIDS Records
I understand if my information requested above contains information in reference to drug and/or alcohol abuse, psychiatric care, psychotherapy notes, sexually transmitted disease, HIV, AIDS, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **CHECK ONE** □ Yes □ No

This protected health information is being used or disclosed for the following purposes:
□ At the request of the individual (use only if request is by the patient or personal representative)
□ Participation in a research study
□ Requested for government benefits
□ Other, (please list the specific purposes): _____

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; the authorization being revoked; or

□ on the following (list expiration date or event): _____

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Center's Privacy Contact, at:

Nora Saavedra, MD
Airline Children's Clinic
5808 Airline Drive
Houston, Texas 77076

I understand that if I later revoke this Authorization, the revocation is not effective for uses or disclosures that the Center has made prior to receiving the revocation.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law under Health Insurance Portability and Accountability Act of 1996.

I understand the Center will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure of protected health information.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Print Name of Patient or Personal Representative

_____
Relationship to Patient, if Personal Representative

[Provide a copy of this form to the patient.]