EVANGELION
MEDICAL

Phone: (432) 699-6000
Fax: (432) 699-6012

**Patient Information:**

Patient Name (print):_____ Date of Birth:____/____/_____
Previous Names:_____
Address:_____City:_____State:_____ Zip:_____
Phone:_____ Email:_____

**Section I: Authorization. Please Select One:**

◯ I hereby authorize Evangelion Medical **to release my medical record** information to the person/facility listed below:
◯ I hereby authorize Evangelion Medical **to obtain my medical record** information from the person/group listed below:

Name/Facility:_____ Attention:_____
Address:_____City:_____State:_____ Zip:_____
Phone:_____ Fax:_____
Purpose of request: ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other:_____
◯ Transfer from Practice (list reason):_____

**Section II: Specific Records/Report(s) to be Released. Please Select One:**

◯ Please provide a two-year abstract of my records | ◯ Other – please be specific and include dates and MD's below:

*** Do not pre-pay**. *You will be invoiced for your selection by our vendor.* **

_____
_____
_____

*COPY FEE: For Patient record requests - Pursuant to HIPAA 45 CFR, 154.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the two-year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the applicable US state statute governing fees for medical records will be applied.*

**Section III: Restricted Authorization to Release Protected Information:**

**IMPORTANT•** It is extremely important that you select either **"I DO"** or **"I DO NOT"** for each item contained in this section. Please do not skip any items as it could impact our ability to fulfill your request and cause delays.

◯ **I DO** or ◯ **I DO NOT** want Mental/Behavior Health or Disability Services Provider Documentation released.*
◯ **I DO** or ◯ **I DO NOT** want HIV/AIDS Screening Test Results released.
◯ **I DO** or ◯ **I DO NOT** want information about Alcohol and/or Substance Abuse Treatment released.**
◯ **I DO** or ◯ **I DO NOT** want Genetic Testing/Test Results released.***
◯ **I DO** or ◯ **I DO NOT** want Confidential Communications with a Social Worker released.
◯ **I DO** or ◯ **I DO NOT** want information about Rape/Sexual Assault Victim Counseling released.
◯ **I DO** or ◯ **I DO NOT** want Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability released.
◯ **I DO** or ◯ **I DO NOT** want information about Sexually Transmitted Disease (STD) released.
◯ **I DO** or ◯ **I DO NOT** want information about Domestic Violence Victim Counseling released.

*This Authorization is not valid for use or disclosure of psychotherapy notes
**Only applicable to records that are created by an "individual or entity who holds itself out as a providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.
***The term "genetic tests" means only those tests which determine future chances of developing a disease but not tests done to diagnose a current condition or problem. This includes information related to the testing of embryos created IVF.

_____
Patient Signature Date

_____
Parent/Legally Recognized Representative Signature / Relationship to patient / Date

**Term**: This Authorization will remain in effect until Evangelion Medical fulfills this request
**Revocation**: I understand that I may revoke this Authorization at any time by requesting it of Evangelion Medical in writing at the address listed above. The revocation will be effective immediately upon Evangelion Medical's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Evangelion Medical in reliance on the Authorization before it received my written notice of revocation.
**Effect on Treatment:** : I understand that I may refuse to sign this Authorization before any reason and that such refusal will not affect the commencement, continuation, or quality of my treatment at Evangelion Medical.
**Potential for Redisclosure**: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it *Is* disclosed by Evangelion Medical.
**Access:** I understand that in certain circumstances P Douglas Cochran, MD LTD has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.