

**CEDAR CREST
3500 S. IH-35
BELTON, TX 76513**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____ (Person/Entity)
_____ (Address)
_____ (City, State, Zip Code)
_____ (Telephone)

to release to: _____ (Person/Entity)
_____ (Address)
_____ (City, State, Zip Code)
_____ (Telephone/Fax)

medical records obtained during the course of treatment of: _____ (Patient Name)
_____ (Date of Birth)
_____ (Social Security Number)
_____ (Dates of Treatment)

Disclosure is necessary for the purpose of _____ and that purpose only. I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. The information to be released includes (please check records to be disclosed pursuant to this Authorization):

___ Discharge Summary	___ Admission Notes	___ Progress Notes
___ Discharge Instructions	___ Mental Status Exam	___ Physician Progress Notes
___ Treatment Plans	___ Medication Records	___ Other: _____
___ Psychological Testing	___ Laboratory Data	___ Verbal Communication with: _____
___ History and Physical Exam	___ Consultation Reports	_____ (Name)
		_____ (Relationship)

The treatment dates covered by this Authorization are from pre-admission to discharge and claims resolution. I understand that information used or disclosed under this Authorization may be subject to redisclosure by the recipient without being further protected under federal and state privacy regulations. I understand that I have the right to refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment.

I hereby release Cedar Crest from all legal responsibilities or liability that may arise from disclosure of my medical records in reliance on this Authorization.

I understand that I have the right to revoke this Authorization at any time, except to the extent that action has been taken in reliance on this authorization. To revoke this Authorization, I must provide a written notice of my intent to revoke along with the date and purpose of this Authorization. This revocation statement must be signed by me and delivered to the facility where I gave my authorization. The revocation will be effective the date it is received by the facility.

I understand that I have the right to receive a copy of this Authorization. I understand that I have the right to inspect the information to be disclosed upon proper notification to, and under appropriate conditions established by, Cedar Crest. This Authorization will automatically expire 60 days from the date of my signature. If patient is a minor, the parent/guardian must sign the Authorization.

_____ Date	_____ Patient	_____ Date	_____ Parent/Guardian
_____ Date	_____ Staff Member/Witness Signature	_____ Guardian's relationship to Patient	