The Cypress Clinic
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Authorization to Disclose Health Information

1. I hereby authorize ______________________________ to disclose the following information from the health record of:

   Patient Name: ______________________________ Date of Birth: ____________________

   Address: ____

   Telephone: ______________________________ Medical Record #: ____________________

   Covering the period(s) of healthcare:

   From (date) ____________________ to (date) ____________________

   From (date) ____________________ to (date) ____________________

2. Information to be disclosed:

   _____Complete Health Record(s)

   ____Discharge Summary ____History & Physical Exam ____Progress Notes

   ____Consultation Reports ____Emergency Report ____Laboratory

   ____X-ray Reports ____Operative Report ____Pathology

   ____Other____

3. I understand that the information in my health record my include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:

   Cypress Clinic, 622 Cypress Street, Sulphur, La. 70663

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information my not be protected by federal confidentiality rules. If I have question about disclosure of the health information, I can contact the Custodian of Medical Records at (337) 527-2491 or at 622 Cypress Street, Sulphur, La 70663.
7. The facility, its employees, officers, and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
8. A reproduction of this document is considered the same as the original.

______________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________ ______________________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness