CYPRESS CLINIC

(Previous address: 11811 FM 1960 W, Ste 198 Houston, TX. 77065)

Mail completed form to: PO Box 9753 Midland, Texas 79708
or Fax completed form to: 432-699-0817
Any questions, please call 432-689-6818 and ask for Medical Records
PLEASE ALLOW 30 BUSINESS DAYS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO ANOTHER PHYSICIAN OR HEALTH CARE FACILITY

I hereby authorize the use or disclosure of information from the medical record of patient

Name_____

Date of Birth _____ Social Security # _____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

Name: Cypress Clinic/Mohsin Syed, MD (formerly at 11811 FM 1960 W, Ste 198 Houston, Tx 77065 / Phone # 281-469-4000)

This information may be disclosed to and used by the following individual or organization:

Name _____Phone: _____Fax:_____

Address _____

For the purpose of: _____
Please release the following:

____ Entire Record
or ____ Problem List
____ Progress Notes
____ EKG Reports
____ List of Allergies
____Laboratory Results – from (date) _____ to (date) _____
____ X-Ray / Imaging Reports – from (date) _____ to (date) _____
____ History / Physical Exam
____ Immunization Records
____Other Diagnostic Reports (Specify) _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.
____ Yes, I consent to the release of this information ____ No, I do not consent to the release of this information

I understand the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand 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 individual or organization releasing information. I understand the revocation will not apply to information already released in response to this authorization. I understand 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 expires upon completion of this request or upon the following date: _____

I understand 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 receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Elizabeth Syed, RN or Janice Kapp.

Signature _____ Date_____

Guardian /Legal Representative _____ Witness _____