Patient Initiated Release of Medical Information

Trinity Clinic

This form may be returned in person to HealthPoint - Trinity Clinic before 12/30/2022, emailed to: MedicalRecords@HealthPoint-tx.com, or mailed to: Medical Records, 1615 Barak Lane, Bryan, TX 77802. All blanks must be filled. If you need help completing this form or have question please call: (979) 977-3010.

Patient Name: _____ Date of Birth: _____ Sex:_____

Address: _____ Cell phone: _____

Alternate phone: _____ E-mail address: _____

I authorize the Center and its administrative and clinical staff to release the following protected health information:

☐ Immunizations (Shot Records)

☐ Entire Record (Excluding HIV & Mental Health, Drug/Alcohol information)

☐ Progress Notes (last 3) ☐ HIV related information (must initial) _____

☐ Labs/Radiology/EKGs ☐ History/Physical ☐ Mental Health, Drug/Alcohol (must initial) _____

☐ Family Planning information ☐ Prenatal Care (Antepartum care, delivery. etc.)

☐ Dental ☐ Other_____

To the following:

☐ Facility or Physician:

Facility or Physician: _____ Phone: _____

Address: _____ Fax: _____

☐ 3rd Party Individual (cannot be a minor, they must present a picture ID if picking up)

Name of Individual_____ Date of Birth_____

Relationship_____

☐ To Myself (note, if you choose this option, the records can ONLY be released to you)

This consent will expire ninety (90) days from the date of my signature, unless otherwise specified. I understand that I may revoke this authorization, except for action already taken, at any time by sending a written notification to the Center's Compliance Contact at:

Attn: Compliance Officer

Mailing Address: 1500 University Dr. East College Station, TX 77840

I understand that if I later revoke this consent, the revocation is not effective for uses or disclosures that the Center has made in reliance on my consent, nor is it effective if my consent was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this Consent may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that my treatment, payment for treatment, enrollment in a health plan, and eligibility for benefits will not be affected if I do not sign this form.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name of Patient or Representative Relationship to Patient

Revised: 11.30.2022

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Delivery

How do you want the records delivered to the recipient?

☐ Faxed ☐ E-Mail: _____

Please include address

☐ Paper Copies (Mailed) ☐ Pick up in person:_____

Please note HealthPoint Clinic location

Contact Method

If there are issues and we need to contact you regarding your request, how would you prefer to be contacted?

☐ Cell Phone ☐ Email ☐ Alternate Phone ☐ Mailing Address

Delivery Time

Records will be ready or sent within 72 hours. Please note, no medical records can be released to minors.

If you have any further questions, please ask the staff.

HealthPoint Staff Use Only

☐ Form Completed

☐ ID Verified and copied

☐ Fee collected (If paper records requested) (no fee for Medicaid, PHC, HTW or FP patients)

☐ Contact info and method confirmed

☐ Delivery time discussed.

Staff Name: _____

☐ Documents scanned and assigned to Medical Records Staff

Revised: 11.30.2022