CENTERVILLE MEDICAL CENTER
DBA CHUKWUMA OSUAGWU MD PA
1015 W. Centerville Rd. Ste. 118 Garland, TX 75041
Office (972) 807-6016 Fax (972) 807-6035

AUTHORIZATION FOR RELEASE OF PATIENT'S PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize _____ to release health records information on:
Name of provider

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ PHONE: _____
CITY/STATE/ZIP: _____ SS #: _____

FOR HEALTH CARE COVERING THE DATE FROM: _____ TO _____
THIS INFORMATION IS TO BE RELEASED TO: _____
NAME OF PERSON/FACILITY: _____ PHONE: _____
ADDRESS: _____ FAX: _____
CITY/STATE/ZIP: _____

INFORMATION TO BE DISCLOSED:				**THE PURPOSE OF THIS DISCLOSURE:**	
☐	Copy of all health records.	SPECIFIC RECORDS:		☐	Continuance of Medical care.
☐	Billing Records:	☐ Laboratory Tests	☐ X-Ray Reports	☐	Attorney
		☐ Progress Notes	☐ Other _____	☐	Insurance
				☐	Other _____

☐ **Records will be faxed or electronically transmitted?**

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that CENTERVILLE MEDICAL CENTER cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or his Privacy Officer.

_____ _____ _____
Signature of Patient/Legally Authorized Representative | Relationship | Date