

RECORD RELEASE FORM

Completing this form authorizes the release and/or use of individually identifiable health information as described below, consistent with applicable state and federal privacy law. Incomplete forms may not be honored.

****SUBMIT COMPLETED FORM TO YOUR MEDICAL PROVIDER****

AUTHORIZATION: I hereby authorize

Provider / Facility Name: _____

Address: _____

Phone #: _____ Fax #: _____

To send my medical records to:

Empower Health, PLLC

1045 Gemini Street, Suite 200B, Houston, Texas 77058

Phone #: 346.444.3024 Fax #: 877.842.3603

Information to be released:☐ COMPLETE MEDICAL RECORDS☐ OTHER: _____**Special Authorization:**

I specifically authorize the release of (check all that apply):

☐ HIV/AIDS testing ☐ Psychological/psychiatric history ☐ Substance Use ☐ Reproductive health**Primary purpose:**☐ CONTINUITY OF CARE☐ OTHER: _____**SIGNATURE**

(Patient/Parent/or Legal Guardian): _____ DATE: _____

Full name: _____ Date of Birth _____

Relationship to Patient: _____

Witness: _____ Verified ID: _____

I understand that I have the right to revoke this authorization at any time. My revocation must be submitted in writing, signed by me or my legal representative, and delivered to Empower Health, PLLC.

My revocation will be effective upon receipt but will not apply to any disclosures already made in reliance on this authorization. I have the right to receive a copy of this authorization. I will not be required to sign this authorization as a condition of receiving treatment or payment, or as a condition of my eligibility for benefits.

Applicable law prohibits the recipient from making further disclosure of this health information unless another authorization is obtained from me, or unless such disclosure is otherwise specifically required or permitted by law.