
Medical Records Release and Authorization for use or Disclosure of Protected Health Information Form

Description and definition of Medical Records Release and Authorization for use or disclosure of Protected Health Information Form: This form disclose our policy regarding releasing your protected health information.

Date:

Time:

Patient Name:

Home Phone (_____) -

Social Security #:

Date of Birth:

I authorized the custodian of records (RejuVenus Aesthetics) of _____ or other/entity (specifically describe) _____ (Check if does not apply) to disclose the following information * (Check all applicable)

- All records
- Laboratory/path reports
- X-ray/radiology reports
- Billing records
- Abstract / summary
- Pharmacy/Prescription records

__Progress note / History and Physical
Other:

_____(Initials) I do or I do not consent to release of information related to psychiatric or psychological testing or treatment, biofeedback training, alcohol and drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, genetic information or such disclosure shall be limited to the following specific types of information:_____.

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the office manager for assistance at 936-760-2696.

This consent shall become invalid and expired 180 days from the date of signature, unless otherwise stated:

Expiration date: _____ or

Expiration event: _____ none _____ or define _____:

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipients of you PHI. Such re-disclosure will no longer be protected by this authorization
2. I have the right to received a copy of this authorization. Copy of the authorization received.

_____(Initials)

The information may be use/disclose for each of the following purposes (Check all applicable):

At my request only (Only the patient can check this box)

For my health care

For payment/insurance

For employment purposes

Other:

I understand that after the custodian of the records discloses my health information, it may not longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payments of your healthcare; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I hereby release RejuVenus Aesthetics (Dr Cortes) from any and all legal liability and injuries that arise from the release of this information to the party named above. I am aware of the HIPPA Privacy Practices for RejuVenus Aesthetics (Dr. Wilberto Cortes) and the copies of RejuVenus Aesthetics patient privacy policy was given to me on _____.

Signature of patient or
legal representative

Date

Patient fee schedule:

The fee schedule for RejuVenus Aesthetics is in accordance on 22 Texas Administrative Code §165.2. and reads as follows:

The physician responding to a request for such information shall be entitled to receive a reasonable, cost-based fee for providing the requested information. A reasonable fee shall be a charge of no more than \$25 for the first twenty pages and \$.50 per page for every copy thereafter. If an affidavit is requested, certifying that the information is a true and correct copy of the records, a reasonable fee of up to \$15 may be charged for executing the affidavit. A physician may charge separate fees for medical and billing records requested. The fee may not include costs associated with searching for and retrieving the requested information.

(2) A reasonable fee, shall include only the cost of:

- (A) copying, including the labor and cost of supplies for copying;
- (B) postage, when the individual has requested the copy or summary be mailed; and
- (C) preparing a summary of the records when appropriate.

I, the undersigned, understand that there will be a fee involved to obtain my records. I hereby agree that I have been informed of such fees by signing below. The invoice needs to be paid prior to mailing the PMI. We only accept cash, credit card and cashier check. In the event you want a copies of the pictures taken at the office a fee of \$30.00 per disk will be charge to you.

Signature of patient or
legal representative

Date