CEREBRUM™
HEALTH CENTERS

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

_____	_____	_____/_____/_____
Name	Soc. Sec. #	Date of Birth
_____	_____	_____
Address	City	State
_____	_____	
Phone	e-mail	

I authorize the following organization _____
to disclose/release the following patient health information* (check all applicable):

- ❑ All records
- ❑ Laboratory/pathology records
- ❑ X-ray/radiology records
- ❑ Billing records
- ❑ Abstract/summary
- ❑ Pharmacy/prescription records
- ❑ Other (describe specifically)

_____

_____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are provided for services on the following date(s): _____

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

Cerebrum Health Centers - Dallas
11511 Luna Rd, Suite 100, Dallas, TX 75234

Phone: 855-444-2724
Fax: 214-496-0955

This authorization shall expire no later than _____/_____/_____ or upon the following event_____
(whichever occurs first), and may not be valid for greater than one year from the date of signature.

I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. I need not sign this form in order to assure treatment.

If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure. By signing below, I represent and warrant that I have the 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.

_____	_____	Date _____/_____/_____
Signature of patient (or patient's representative)	Printed name of patient/representative	