# Authorization for Release of Protected Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Facility/Doctor Name: _____

Address: _____ City, ST, Zip: _____

Phone Number: _____ Fax: _____

**I, Patient Name: _____ Date of Birth: _____, authorize you to disclose the Protected Health Information described below to:**

Retro Health, LLC
13755 Diplomat Dr., Suite 100, Farmers Branch, TX 75234
Phone: (833) 600-9355, Option 8 Fax: (833) 673-0556
Email: Info@RetroHealth.com

The complete history records in your possession concerning my illness and treatment for **Continuation of Care**:

| | | |
|---|---|---|
| _____ All Health Information | _____ Consultation Reports | _____ Pathology/Lab |
| _____ History & Physical | _____ EKG/Cardiology Reports | _____ Discharge Summary |
| _____ Progress Notes | _____ Diagnostic Test Reports | _____ Radiology Reports & Images |
| _____ Past/Present Medications | _____ Patient Allergies | _____ Operations Reports |

Please release the information for the following dates/time-period: _____

Date Records Needed By: _____ Please Mail, Fax, or Email (All Secure)

My initials below indicate special permission to release any information other than indicated above:

| | |
|---|---|
| _____ Drug, Alcohol, or Substance Abuse Records | _____ Genetics (including test results) |
| _____ HIV/AIDS Test Results and Treatment | _____ Mental Health Records |

This authorization shall be in force and effective for 6 months from the date of signature. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Retro Health, LLC. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

| | | |
|---|---|---|
| _____ | Self _____ | _____ |
| Signature of Patient or Legal Representative | Relationship to Patient | Date |

| | |
|---|---|
| _____ | _____ |
| Approved by Retro Health's Representative | Date |