Dominguez Psychotherapy and Counseling Center

Corporation Mailing Address:
Dominguez Psychotherapy and Counseling Center, Inc.
1406 Lexington Blvd. Missouri City, Texas 77489
Phone: 346-241-1416 Medical Records Fax: 346-402-4017

Authorization for Release of Health Information

I, ______________________ hereby authorize Dominguez Psychotherapy and Counseling Center (and their agents) to disclose my health information as described in this authorization.

[1] Specific person(s)/organization(s) to whom Dominguez Psychotherapy and Counseling Center is authorized to disclose the information:

Specific person(s)/organization(s):
____

Address/email/fax: ____

____

[2] Specific description of the information to be disclosed by Dominguez Psychotherapy and Counseling Center:

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[3] ***Right to Revoke***: I understand that I have the right to revoke this authorization at any time by notifying Dominguez Psychotherapy and Counseling Center in writing at 1406 Lexington Blvd. Missouri City, TX 77489. I understand the revocation is only effective after it is received by Dominguez Psychotherapy and Counseling Center. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

[4] ***Potential for Redisclosure***: I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it.

5. [5] Right ***to Copy***: I understand that I am entitled to receive a copy of this authorization.
6. [6] Expiration ***of Authorization***: This authorization will expire [choose one]:

   ___ On the _____ day of _______________, 20_____.
   ___ Upon the occurrence of the following event: ________________________

[7] ***Voluntary***: I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party or parties I have designated.

[8] ***Purpose of Authorization***: I am requesting that my Protected Health Information be disclosed for the following purpose:
____.

[9] ***Photocopy or Facsimile***: A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had the opportunity to review and understand the contents of this form. By signifying this form, I am confirming that it accurately reflects my wishes.

____________________ _________________________________
Date Individual Signature

Complete the following only if you are a Personal Representative signing the form on behalf of the individual.

If a Personal Representative executes this form on behalf of the individual, the Personal Representative warrants that he or she has authority to sign this form on the basis of:

____ A power of attorney for health care purposes including the right to access protected health information (copy attached).

____ A court order of appointment as the conservator or guardian of the individual (copy attached).

____ An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law exceptions).

____ Other: ____.

NOTICE TO RECEIVING AGENCY/PERSON:

This information is confidential, and you may not disclose any information unless the person consents. You are bound by Federal and Texas law regarding confidentiality of patient records; neither such records nor information from such records may be further disclosed without specific authorization.

Completed request forms may be submitted in the following ways:
Email: Records@DominguezPsychotherapy.com
Fax: 346.402.4017
Mail:
Dominguez Psychotherapy & Counseling Center
c/o Records Department
1406 Lexington Blvd.
Missouri City, TX 77489
Please allow 5-7 business days for records request. For questions regarding medical records or to obtain the status of your request call us at 346.241.1416