Margit Winstrom, MD
Esaias I. Baca, DC
2211 Norfolk Street, Suite 105
Houston, TX 77098
Phone: 346-348-2222
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Authorization to Release Medical Information

All portions of this form *must* be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Requesting Medical Release:

Patient Name:_____Date of Birth:_____/_____/_____SSN:_____ - _____ - _____

Address:_____State:_____Zip:_____Phone:_____

Facility/Practitioner Authorized to (Release / Receive) my Health Information (Circle one):

Physician Name/Clinic Name:_____

Address:_____City:_____State:_____Zip:_____

Phone Number_____ Fax Number:_____

Facility/Agency/Individual(s) Authorized to (Receive / Release) my Health Information:

❒ Dr. Margit Winstrom
❒ Dr. Esaias I. Baca

At: Flux Metabolic Restoration Center
2211 Norfolk Street, Suite 105
Houston, TX 77098
Phone: (346) 348-2222 / FAX: (713) 522-3047

Health Information that may be used/disclosed is limited to the following:

❒ Entire Records
❒ History and Physical Exam
❒ Laboratory/Pathology Reports
❒ Diagnostic images/video
❒ Operative Notes/
❒ Discharge Summary
❒ Other (must be specific):
_____
_____

Authorization:

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing, facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include, alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

I understand further use or disclosure of the authorized information by the above named agency/individual may not be accomplished without my further written authorization. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have the right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.
NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.
I, hereby authorize the use and disclosure of my private medical records, by way of:

❒ Mail ❒ Fax ❒ Phone ❒ Oral ❒ Email: Provide email:

Patient's Signature or Authorized Party:_____Date:_____Time:_____

Relationship to Patient:_____Interpreter, if utilized:_____

Witness' Signature:_____Expiration Date or Event:_____