MEDICAL RECORDS REQUEST INSTRUCTION

If you are a **caseworker, doctor, legal representative or a VA representative**, please use the following steps to request a client's medical records from Cenikor Foundation:

1. Print out Cenikor Foundation's Authorization for Release of Health Information.
2. Pursuant to 42 CFR, Cenikor Foundation requires the form to be signed by the client.
3. Scan the signed copy of the form and send the request along with your letter to medicalrecords@cenikor.org.

Note: Upon receipt of the request, Cenikor Foundation will process your request within 1-3 business days. The consent release form is attached to this instruction.

If you are a **client** requesting your medical records, please use the following steps to complete your request:

1. Print out Cenikor Foundation's Authorization for Release of Health Information.
2. Pursuant to 42 CFR, Cenikor Foundation requires the form to be signed by the client.
3. Make a money order or a cashier's check in the amount of $25 payable to: Cenikor Foundation, 11931 Wickchester Lane, Ste. 300, Houston, Texas 77043.

Note: There is a $25 processing fee which must be paid before your request is processed. Please note that cash and checks are not acceptable form of payment. Fill out the attached form and email it to medicalrecords@cenikor.org if you would like to pay using a debit/credit card.

CENIKOR
WELL BEYOND RECOVERY

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. I, _____ (Patient Name), hereby authorize **Cenikor Foundation** to release health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 to:

   Name: _____
   Phone: _____
   Address: _____

2. Information of:
   Patient Name: _____
   Date of Birth and/or Social Security No._____
   Phone: _____

3. Information is to be limited to the following Dates of Treatment (if applicable):
   _____

4. Information requested to be released:

   _____ Psychotherapy Notes Only
   _____ Alcohol and Drug Abuse Treatment (Substance Abuse)
   _____ Mental Health Treatment (*except psychotherapy notes*)
   _____ Confidential HIV Related Information
   _____ Case & Session Notes
   _____ Lab Work
   _____ Medication Administration
   _____ Other (specify)

5. Purpose of access or release:
   _____ Medical Care ____ Insurance or Other Payment
   _____ At Request of the Patient
   Other (explain): Legal Proceedings

6. This authorization will expire on the following date: _____.
   If no date is specified, this authorization shall expire one (1) year from the date signed below. I understand that I may revoke this authorization at any time by giving written notice to Cenikor Foundation, except that a revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

7. Cenikor Foundation, its employees and any physicians on staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that any alcohol, drug abuse and mental health treatment (substance abuse) information disclosed is prohibited from further disclosure **unless I expressly permit further disclosure or the disclosure is permitted by federal regulations** (42 C.F.R. Part 2.32).

_____ _____
Signature of Patient or Legal Representative **Date**

If Legal Representative, authority of Legal Representative
_____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

PROVIDE COPY TO PATIENT/LEGAL REPRESENTATIVE

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CREDIT CARD AUTHORIZATION FORM

Client Name: _____ Date: _____

We have received your request for your medical records. Please pay your total in full so we may process the request.

Charges for your records:

$25 for 500 pages or less

$50 for more than 500 pages

Total: _____

PAYMENT INFORMATION

Credit Card Type: Visa Mastercard Discover American Express

Card Number: _____ **CVC:** _____ **Expiration:** _____

Name on Card: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Email:** _____

Signature: _____ **Date:** _____