AVENUE360 HEALTH + WELLNESS

AUTHORIZATION TO REQUEST AND/OR RELEASE MEDICAL AND/OR DENTAL RECORDS

Patient Requesting Information				Today's Date: / /
Last Name:	First Name:	MI:	Date of Birth: / /	Preferred Phone: □ Home □ Cell ( ) -
Home Address:	Apt #	City:	State:	Zip Code

I hereby authorize AVENUE 360 HEALTH AND WELLNESS
□ TO RELEASE OR □ TO RECEIVE FROM:

Name of Clinic/Doctor and/or Person: _____

Street Address: _____

City, State and Zip: _____

Phone: _____

Fax: _____

Avenue 360 Site Requesting or Releasing Records (Please Check one)**:**

☐	2150 W. 18th St., Suite 300, Houston TX 77008	Ph: (713) 426-0027	Fax: (832) 649-3944
☐	17010 Sugar Pine Dr., Houston TX 77090	Ph: (281) 537-8627	Fax: (832) 649-3944
☐	902 Frostwood Dr., Suite 142, Houston TX 77024	Ph: (713) 827-8266	Fax: (713) 827-0132
☐	1427 Hawthorne St., Houston TX 77006	Ph: (713) 341-3790	Fax: (832) 649-3944
☐	9816 Memorial Blvd., Suite 120, Humble TX 77338	Ph: (281) 570-2525	Fax: (832) 649-3944
☐	4405 Griggs Road, Houston TX 77021	Ph: (832) 962-4111	Fax: (832) 649-3944
☐	14095 S. Main St., Houston TX 77035	Ph: (832) 830-8345	Fax: (832) 649-3944
☐	602 Branard St., Houston TX 77006	Ph: (713) 523-7110	Fax: (713) 526-4145
☐	1429 Hawthorne St., Houston TX 77006	Ph: (713) 341-3790	Fax: (281) 822-0169

If you want all records identified below exchanged, released and/or disclosed, only initial the blank next to "Entire Clinical Records and/or Entire Dental Records", or initial only the documents you want exchanged, released and/or disclosed.

____Treatment Plans & Medications	____CPCDMS Forms	____Other records as specified:
____Operative Reports	____HIV/AIDS Status/Records	_____
____Entire Clinical Records	____Progress Notes	____Communicable Disease
____Entire Dental Records	____Discharge Summary	____Radiology Reports
____All Billing Records Only	____Pathology Reports	____Alcohol/Drug Treatment
____History and Physical(s)	____Lab Reports	____Psychiatry Records
____Consultations		

Date(s) of service: _____

Purpose of Disclosure: ☐ Continuum of Care **OR** ☐ Other (specify): _____

I UNDERSTAND THAT:

1) The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse,
2) I may revoke this authorization in writing by contacting Avenue 360 Health & Wellness,
3) This authorization will not affect treatment, payment, enrollment, or eligibility for benefits and
4) Information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law and no longer be protected by the Health Insurance Portability and Accountability Act 1996.

EXPIRATION DATE:

This authorization will expire on the following date: _____ or 180 days from the date of signature. I understand that this authorization may be revoked by the person giving the authorization by written and dated notice to Avenue 360 Health & Wellness, except to the extent that disclosure of information has been made prior to receipt of the revocation by Avenue 360 Health & Wellness. A photocopy of this Authorization shall be considered valid as original.

PLEASE MARK ONE:

This form ☐ was read by me or ☐ was read to me, and I understand its meaning. All the blanks were filled in before I signed the form.

Print / Type Name of Person Authorized to Consent to Release of Information: _____

Signature of Authorized Person: _____

FOR OFFICE USE ONLY

Name of Requesting Provider:_____ Date: _____