# *RELEASE OF INFORMATION FOR MEDICAL RECORD OF:*

**PATIENT NAME:** _____

**PATIENT ADDRESS:** _____

**PATIENT DATE OF BIRTH:** _____

**PATIENT DATE OF SERVICE:** _____

**PATIENT PHONE #:** _____ **PATIENT SSN:** _____

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I hereby authorize _____ to release information and forward to:

(provider)

_____

_____

_____

_____

Please check type of information to be released:

| | | |
|---|---|---|
| Complete Medical Record | Lab Results | X-Ray Results/Film |
| Notes/Results for DOS: | Consultation Reports | Billing Records |
| Immunizations | Other, please specify | |

Please check the reason the above information is released:

| | | |
|---|---|---|
| Transfer to another physician | Legality Purposes | Specialist/2nd opinion |
| Personal File | Disability Benefits | Other, please specify |

I understand that the specific information to be disclosed may include history of DRUG AND ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME(AIDS), and laboratory test results, treatment progress or any other such related information.

I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for per-employment purposes. However, no protected information will be release without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy and Individually Identifiable Health Information (45 CFR parts 160 & 164).

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire 180 days from the date of my signature on or otherwise specified by date, event or condition as follows:

_____

I further authorize that a photocopy of this authorization is acceptable as an original.

I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing Law.

_____ _____

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

_____

**Relationship to Patient**

Date of Request: __/__ /__ Record copying cost: $ _____.00 _____ Cash _____ Check # _____ C.C.