

RELEASE OF INFORMATION FOR MEDICAL RECORD OF:

PATIENT NAME _____

PATIENT ADDRESS _____

PATIENT DATE OF BIRTH _____

PATIENT DATE OF SERVICE _____

PATIENT TELEPHONE # _____

PATIENT SSN _____

√ 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 Date of Service:	Consultation Reports	Billing Record
Immunizations	Other, <i>specify</i>	

√ **Please check the reason the above information is released:**

Transfer to another physician	Legality Purposes	Specialist/2 nd Opinion
Personal File	Disability Benefits	Other, <i>specify</i>

- √ I understand that the specific information to be disclosed may include history of DRUG or 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 pre-employment purposes. However, no protected information will be released 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 of 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 in 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.

Divorced Parents: This is to certify that I, _____, have full access to my child's medical record according to the divorce decree granted by the court.

*Patient/Parent/Guardian Name: _____

*Patient/Parent/Guardian Signature: _____

Signature of Patient or Legal Representative

Date

Relationship to Patient

Identity of Requestor Verified via: *Photo ID* *Matching Signature* *Other, specify* _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal & State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500, in case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

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



**RELEASE OF INFORMATION
 FOR MEDICAL RECORDS**