

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, \_\_\_\_\_, hereby **voluntarily authorize the disclosure** of information from my health record.

**NAME:** \_\_\_\_\_ **RECORD NUMBER:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **PATIENT SSN:** \_\_\_\_\_

**INFO REQUESTED:**

\_\_\_\_\_  
 \_\_\_\_\_

**PURPOSE OF RELEASE:**

\_\_\_\_\_  
 \_\_\_\_\_

**THIS INFORMATION IS TO BE PROVIDED TO:**

**NAME OF PERSON/ORGANIZATION/FACILITY** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

1. I understand that this authorization will **expire** on (insert date)\_\_\_\_\_.
2. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying (insert name of practice) in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

**Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS or psychology notes will be disclosed. One signature required here.**

Effective March 26, 2013, Psychotherapy notes will not be used or disclosed without patients' written authorization.

YES, disclose this information       NO, do NOT disclose this information

**PATIENT / PATIENT'S REPRESENTATIVE SIGNATURE** \_\_\_\_\_

**PRINTED NAME OF PATIENT'S REPRESENTATIVE** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_ **DATE** \_\_\_\_\_

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM**

**HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 2014** This form does not constitute legal advice and covers only federal, not state, law.

**Under HIPAA with patients' written request, records must be provided within 30 days of a request.**

Under House Bill 300 Texas Law with patient's written request, records must be provided within 15 days of a request.