FAMILY MEDICINE CENTER
701 McClintic Dr
Groesbeck, TX 76642
Tel: 254-729-3411 Fax: 254-729-3258

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

Please read before signing: *Complete only the sections that apply, DO NOT SIGN BLANK FORM*

Patient Name: _____ DOB: _____

Address: _____ City, State_____

Phone: _____ SS# xxx-xxx-_____

I authorize and direct (facility that will RELEASE information):

Name: _____

Address: _____

Phone: _____ Fax: _____

To release the following confidential health information to (recipient):

Name/Organization: _____

Address: _____

Fax: _____ Email: _____

PURPOSE OF DISCLOSURE (check one): ☐ Continuity/Coordination of Care
☐ Liability Insurance ☐ Attorney ☐Personal use ☐ Other: _____

INFORMATION TO BE RELEASED (check all that apply):
☐ All records ☐Office/Clinic notes ☐ Lab ☐ Radiology/X-ray ☐ History & Physical ☐ EKG
☐ Procedure reports ☐ Immunization record ☐ Billing/charges ☐ Other: _____

SENSITIVE INFORMATION (release ONLY if initialed):
☐ Mental health/behavioral health records ☐ HIV/STD info ☐ Alcohol/Drug treatment (SUD) records ☐ Other sensitive information: _____

DATES OF SERVICE: ___All dates OR From _____ to _____

DELIVERY METHOD (check one): ☐ Mail ☐ Fax ☐ Secure email ☐ Patient portal
☐ Other: _____ PLEASE **NO CDs**

If email is requested: Email address _____I understand unencrypted email can be read by others.

FEES: I understand there may be a charge for copies as permitted by Texas law, unless records are sent directly to another health care provider.

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PATIENT RIGHTS AND HIPAA REQUIRED STATEMENTS:

1) I understand that I may revoke this authorization at any time by submitting a written request to the releasing facility's Health Information Management/Medical Records Department at the address above, except to the extent action has already been taken in reliance on this authorization.

2) I understand that this authorization is voluntary and that treatment, payment, enrollment, or eligibility for benefits are not conditioned by signing.

3) I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

4) I have the right to receive a copy of this signed authorization.

EXPIRATION: This authorization expires in 180 days from the date signed OR when a request to revoke has been signed.

SIGNATURES:

_____ _____ _____
Signature of Patient Printed name of Patient Date

OR

_____ _____ _____
Signature of legal representative Printed name of representative Date

Relationship/authority to act for patient _____

(If you sign as the patient's personal representative, you must describe your authority (e.g., parent of minor, legal guardian, medical power of attorney, executor of estate.)