



RUCKER MEDICAL CLINIC

200 N Pearl St

Mart, TX 76664

Tel: 254-8769020 Fax: 254-795-1513

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.)