Medical Release of Consent

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Email (Optional): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

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□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:

(Choose all that Apply)

□ Treatment/Continuing Medical Care

□ Personal Use

□ Billing or Claims

□ Insurance

□ Legal Purposes

□ Disability Determination

□ School

□ Employment

□ Other (Specify): _____

Patient Signature: _____ Date: _____