AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____

Entity/Person **from** whom records are requested; Include full name

_____

Complete address,

_____

City, State, ZIP, Telephone and Fax.

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name _____

Date of Birth ☐☐/☐☐/☐☐☐☐ (MM MM DD DD YY YY YY YY) Social Security Number ☐☐☐-☐☐-☐☐☐☐

Patient Address _____ Phone Number (____) ____ - _____

Date(s) of Service (if known) _____

Description of information to be released: (Check ✓ all that apply)

____ Emergency Room	____ Radiology Reports	____ Admission / Registration	____ Other: _____
____ History & Physical	____ Consultation Reports	Records	_____
____ Nurse's Notes	____ Physician's Orders	____ Laboratory Reports	_____
____ Progress Notes	____ Operative Records	____ Billing Records	_____
____ Discharge Summary	____ Radiology Films		

Description of the purpose of the use and / or disclosure:_____

_____

The health information described herein shall be released to: (Check ✓ the appropriate category)

___Hospital ___✓Physician ___ Insurance Company ___ Attorney ___ Patient ___ Other

(Check ✓ the appropriate delivery method)

Name: Family Medical Center at Garland _____Mail _____Fax

Address: 601 Clara Barton, Suite 200, Garland, TX 75042 _____Pick-up Records

Phone Number: 972-272-6561 Fax Number: 972-272-7159 _____Other_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____ (Expiration date / event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative

PATIENT IDENTIFICATION NO. _____

PATIENT _____

PHYSICIAN _____

Family Medical Center at Garland
601 Clara Barton, Suite 200
Garland, TX 75042
PH: 972-272-6561 FX: 972-272-7159