



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 of Patient)

Patient Name: _____ Record Number: _____

Patient's Date of Birth: _____ Patient's SSN: _____

Information Requested:

Purpose of Release:

The Information is to be provided to:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

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.

Patient's Signature or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

*Under HIPAA with patients' written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with patients written request, records must be provided within 15 days of a request.*

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.