FAMILY MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	**Date of Birth**	**SS#**
Patient Street Address	**City & State**	**Zip Code**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.
In accordance with Texas State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-RELEATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the Texas State Health and Human Service Commission Civil Rights Office at (512) 438-4313. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I amy revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of healthcare provider or entity to release information:

8. Name and address of person(s) or category of person to whom this information will be sent:
FAMILY MEDICAL CENTER, 190 BUTTERCUP CREEK BLVD, CEDAR PARK, TX 78613 (FAX 512-336-5293)

9. (a) Specific information to be released:
   - ☐ Medical Record from (insert date) _____ to (insert date) _____
   - ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology results, films, referrals, billing records, insurance records, and records sent to you by other healthcare providers.
   - ☐ Other: _____

   (b) Authorization to discuss health information:
   - ☐ By initialing here _____ I authorize ***FAMILY MEDICAL CENTER*** to discuss my health information with my attorney or governmental agency listed here:

     _____

     _____

10. Reason for release of information
    - ☐ At request of individual
    - ☐ Other: _____

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been offered a copy of this form.

_____ _____

Signature of patient or representative authorized by law Date