

Consent / Authorization for Release of Information

1.	I hereby authorize:		
	Name:	Address:	
	City:	State:	Zip:
	Phone:	FAX:	
	To release the following information from the health record (s) of		
	Patient's Name:		
	Phone Number:		
	Covering the period (s) of treatment: From	om:	10:
2.	Information to be released:		
	☐ Progress Note	Mail Co	pies:
	Radiology	Patient	Pick-Up:
	☐ Lab	FAXED	:
	☐ Billing Records		
	☐ X-ray Films		
	☐ Complete Medical Record (includes information regarding insurance, demographic, referral documents and records.)		
3.	Information is to be released to:		
	Name:	Address:	
	City:	State:	Zip:
	Phone:	FAX:	
	Purpose of disclosure (circle one): Treatment Payment Healt	th Care Operations	Other (Specify Below)
1.	I understand that I may revoke this consent/authorization at any time by notifying Texas On writing.		
	I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.		
5.	THIS AUTHORIZATION WILL REMAIN IN EFF	ECT UNTIL REVOK	ED BY ME IN WRITING.
6.	The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.		
7.	I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.		
*	There is a \$25.00 fee for the first 20 pages, and \$ Please allow two wee		
	Signature:	Date: _	
	Signature: Date: Date:		
	Witness:	Relationship: _	