Authorization to Release Health Information

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Date(s) of Service: _____ through _____

I hereby authorize _____ to obtain true and correct copies of the health care information (including any and all individually identifiable health information under HIPAA regulations) identified below pertaining to the history, diagnosis, treatment or prognosis of the Patient below.

PATIENT INFORMATION (Please Print):

First Name:	Middle Initial:	Last Name:	Last 4 of SSN:

Name at Time of Treatment (if different than above):

Date of Birth (MM/DD/YYYY):	Phone:	Fax:	Email:

Street Address (Address/City/State/Zip):

Release of Information Via:	☐ Personal Pickup	☐ Mail Address:	☐ Fax Number:	☐ Email Email:

PLEASE RELEASE THE FOLLOWING INFORMATION

☐ All health information	☐ Nurse Visit Notes	☐ Billing Information
☐ Physician Orders	☐ Patient Allergies	☐ Past/Present Medications
☐ Visit Notes	☐ Medication Lists	☐ Referral Documentation
☐ Other:		

****Your initials are required to release the following information listed below:**

_____ Mental Health Records (excluding psychotherapy notes)	_____ Genetic Information (Including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records	_____ HIV/AIDS Results/Treatment

PURPOSE OF DISCLOSURE (Choose ONE option below):

☐ Treatment/Continuing Medical Care	☐ Personal Use	☐ Billing or Claims
☐ Insurance	☐ Legal Purposes	☐ Disability Determination
☐ School	☐ Employment	☐ Other:

- **EFFECTIVE TIME PERIOD:** This authorization is valid until the earlier of the occurrence of the death of the individual, the individual reaching the age of majority, permission is withdrawn, or the following specific date (optional):
  Month _____ Day _____ Year _____
- **RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the persons or organizations noted below: "WHO CAN RELEASE, DISCLOSE, RECEIVE, AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
- **SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosures of health information that has occurred prior to revocation or that it is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by the Texas Health & Safety Code § 181.154 and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that there may be a fee charged for copying the requested information. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

I AUTHORIZE THE FOLLOWING TO RELEASE AND DISCLOSE THE INDIVIDUAL PROTECTED HEALTH INFORMATION (PHI):				**LIST WHO CAN RECEIVE AND USE THE PROTECTED HEALTH INFORMATION (PHI):**			
Person/Organization Name: Clearfork Health Center				**Person/Organization Name:**			
Address: 774 State Hwy 70 N	**City:** Rotan	**State:** TX	**Zip:** 79546	**Address:**	**City:**	**State:**	**Zip:**
Phone: 325-735-2211	**Fax:** 833-449-1354			**Phone:**	**Fax:**		

SIGNATURE AUTHORIZATION

Signature of Individual or Individual's Legally Authorized Representative _____ Date Signed	Printed Name of Legally Authorized Representative (if applicable) **Relationship to Patient:** ☐ Parent of Minor ☐ Legal Guardian ☐ Other:

A minor individual's signature is required for the release of certain types of information, including, for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol, or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

Signature of Minor Individual _____ Date Signed	Printed Name of Minor Individual

Witness Signature:	Records Released By:	Date/Time Released:

Please Note: The Medical Record department at Clearfork Health Center does not process or release medical records on behalf of Fisher County Hospital District. If you need records from Fisher County Hospital District, please contact their Medical Records department directly for assistance, or call 325-735-2256, ext. 205.