

**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):					
<b>Release of Information Via:</b>		<input type="checkbox"/> Personal Pickup	<input type="checkbox"/> Mail Address:	<input type="checkbox"/> Fax Number:	<input type="checkbox"/> Email Email:
PLEASE RELEASE THE FOLLOWING INFORMATION					
<input type="checkbox"/> All health information	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Billing Information	<input type="checkbox"/> Radiology Reports/Images		
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Patient Allergies	<input type="checkbox"/> Diagnostic Test Results	<input type="checkbox"/> Cardiac Rehabilitation Notes		
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Lab Results	<input type="checkbox"/> Physical Therapy Records		
<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> Other (Specify): _____				
**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):					
<input type="checkbox"/> Treatment/Continuing Medical Care		<input type="checkbox"/> Personal Use		<input type="checkbox"/> Billing or Claims	
<input type="checkbox"/> Insurance		<input type="checkbox"/> Legal Purposes		<input type="checkbox"/> Disability Determination	
<input type="checkbox"/> School		<input type="checkbox"/> Employment		<input type="checkbox"/> Other:	
<ul style="list-style-type: none"> <li>➤ <b>EFFECTIVE TIME PERIOD:</b> 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 _____</li> <li>➤ <b>RIGHT TO REVOKE:</b> 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.</li> <li>➤ <b>SIGNATURE AUTHORIZATION:</b> 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 &amp; 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.</li> </ul>					
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: Fisher County Hospital District			Person/Organization Name:		
Address: 774 State Hwy 70 N		City: Rotan	State: TX	Zip: 79546	
Address:		City:	State:	Zip:	
Phone: 325-735-2256		Fax: 325-735-3070		Phone:	
				Fax:	
SIGNATURE AUTHORIZATION					
Signature of Individual or Individual's Legally Authorized Representative			Printed Name of Legally Authorized Representative (if applicable)		
Date Signed			Relationship to Patient:		<input type="checkbox"/> Other:
			<input type="checkbox"/> Parent of Minor		<input type="checkbox"/> Legal Guardian
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			Printed Name of Minor Individual		
Date Signed					
Witness Signature:			Records Released By:		Date/Time Released:

Please Note: The Medical Record department at Fisher County Hospital District does not process or release medical records on behalf of Clearfork Health Center. If you need records from Clearfork Health Center, please contact their Medical Records department directly for assistance, or call 325-735-2211 EXT 226.