Authorization for Release and Disclosure of Protected Health Information

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Address:_____ City:_____ State:_____ Zip: _____

Soc. Sec. No.:_____ Telephone:_____

In accordance with state law and regulatory agency requirements, the health record is the property of River Hills Family Medicine. Specialty clinic charts are kept separate from your primary care chart and must be requested separately

I hereby authorize that my medical information be released: ☐ Pick-up ☐ Mail ☐ Fax (emergency only)

To: Name:_____ From: Name:_____

Address:_____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Telephone:_____ Telephone:_____

Please release the following information:

☐ Problem List	☐ X-Ray Reports	☐ Mental Health
☐ Progress Notes	☐ X-Ray Films	☐ Drug/Alcohol
☐ History and Physical Exam	☐ EKG Reports	☐ Lab Reports
☐ Immunizations	☐ Outside Records	☐ Medications
☐ HIV/AIDS Test	☐ Correspondence	☐ Previous Release of Information
☐ Other (specify)_____		☐ Date of Service_____

This information is necessary for the following purpose:

☐ Continued Patient Care ☐ Insurance ☐ Personal Use ☐ Attorney/Legal ☐ Other (specify)_____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoke, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Office Manager at (512) 345-7436.

River Hills Family Medicine may receive direct or indirect remuneration as a result of disclosing this information due to_____

Patient Signature:_____ Date:_____

Witness Signature:_____ _____
Name Relationship

With respect to clients receiving chemical dependency services, this information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec. 290-dd(2).

Please return completed form to the appropriate physician's office.

Authorization for Release and Disclosure of Protected Health Information, cont'd.

Office Use Only

Information Copied:

- ☐ Problem List
- ☐ Progress Notes
- ☐ History and Physical Exam
- ☐ Immunizations
- ☐ HIV/AIDS Test
- ☐ Other (specify)_____
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ EKG Reports
- ☐ Outside Records
- ☐ Correspondence
- ☐ Mental Health
- ☐ Drug/Alcohol
- ☐ Lab Reports
- ☐ Medications
- ☐ Release of Information
- ☐ Date of Service_____

Date Request Received:_____

Date Request Completed:_____

Charges: $ _____

Patient Requesting Access to Medical Record:_____

Access to Medical Record: ☐ Approved ☐ Denied

Letter of denial sent to patient: ☐ Yes ☐ No

Employee Completing Request:_____

Employee's Title: _____

Comments: _____

_____

_____

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Please return completed form to the appropriate physician's office.