FAMILY CARE & WELLNESS

Helping you be a healthier you

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Name of Patient)_____ (DOB)_____

I hereby authorize (Provider Name)_____ (Provider Address)_____
(Provider Phone #)_____ (Fax #)_____to release health record information for Healthcare Covering the Period(s) from (date)_____ to (date)_____:

- May include another healthcare facility or healthcare providers' records? □ Yes □ No
- May records be faxed, mailed or electronically transmitted? □ Yes □ No

This information is to be released to **FAMILY CARE AND WELLNESS, PLLC., which is located at 915 W EXCHANGE PKWY SUITE 210 ALLEN, TX 75013, phone # (469) 656-1033, fax # (855) 231-4739.**

The purpose of this disclosure is for:

☐ Continuing Medical Care ☐ Personal Use ☐ Legal Purposes ☐ School ☐ Employment
☐ Insurance ☐ Other _____

Information to be disclosed may include:

□ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
□ Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records
□ Billing Records
□ Specific records: **Progress Notes_____ Laboratory Tests _____ Radiology Reports _____**
Other _____

I understand that the information released as a result of this Authorization for Release of Protected Health Information (PHI) may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release. I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider. I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation. Unless otherwise indicated, this authorization will expire twelve months (12) from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization by Family Care and Wellness upon request. I understand and agree that my medical record will be maintained in a paper or electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system. I understand that Family Care and Wellness cannot require me to sign this Authorization as a condition to provide services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or Family Care and Wellness' Privacy Officer.

Signature of Patient/Representative_____ Date _____

Representative Name _____ Relationship _____