AMARILLO URGENT CARE

MR#

1915 Coulter Amarillo, TX 79106
(806) 352-5400; FAX: (806) 352-8555

Authorization for Release of Health Information

THIS IS A LEGAL DOCUMENT, PLEASE READ IT AND FILL IT OUT COMPLETELY

PATIENT NAME:	LAST	FIRST	MI	MAIDEN OR OTHER NAME

DATE OF BIRTH: *(Mo./Day/Year)*	SS #: (Optional)	DAY PHONE:	EVENING PHONE:

I AUTHORIZE THE RELEASE (DISCLOSURE) OF MY HEALTH INFORMATION:

FROM:			
NAME:			
ADDRESS:	CITY	STATE	ZIP
PHONE:		FAX:	
TO:			
NAME:			
ADDRESS:	CITY	STATE	ZIP
PHONE:		FAX:	

PURPOSE OF DISCLOSURE: Changing Physicians Consultation/second opinion Continuing Care Legal School Insurance Self Disability Determination Workers Compensation Other (please specify):_____

INFORMATION TO BE RELEASED: (Please Circle One,) Discharge Summary Progress Note Pathologist Referral Radiologist Report History and Physical Operative Note Laboratory Referral EKG Consultation Report Full Summary Sheet Other

MY RIGHTS:

1. I understand that the information released from my health record may include information relating to treatment of alcohol or drug abuse, behavioral or mental health services, as well as HIV/AIDS testing unless otherwise limited.

2. I understand that this authorization will expire 12 months after I have signed the form or _____. The photocopy or fax of this authorization is valid in this original.

3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

4. I understand that the authorization of disclosure of health is voluntary. I can refuse to sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

6. I understand that my physician will not condition my treatment, payment, enrollment in health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services provide, to me solely for the purpose of creating protected health information for disclosure to a third party.

7. I understand I will be charged a fee for the processing and copying of the release of my records. The charges are as follows: $10 search and handling fee, plus 0.50 per page for the first 50 pages and 0.25 per page thereafter and any postage fees.

I certify that this form...

_____ _____ OR _____
SIGNATURE OF PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE PERSON

_____ _____ OR _____
PATIENT NAME DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

IDENTIFICATION PRESENTED FOR SIGNATURE:_____ DATE REQUEST FILLED/BY WHOM:_____
IDENTIFICATION PRESENTED (IF OTHER THAN PATIENT PICKING UP)_____