AUSTIN REGIONAL CLINIC

# Authorization for Release and Disclosure of Protected Health Information to Austin Regional Clinic

MRN: _____

**Tel:** | **Fax:**

I hereby authorize the Medical Record Custodian of the office of Dr. _____ to release information from the medical record of:

Patient Name: _____ Date of Birth: _____

Address: _____ Tel: _____

City: _____ State: _____ Zip: _____

Date of Service: _____

**Information May be Released To: AUSTIN REGIONAL CLINIC**

_____
Medical Practice/Doctor

_____
ARC Clinic

_____
Address, City, State, Zip

_____ _____
Phone Fax

**Information Will be Released From:**

_____
Medical Practice/Doctor

_____
Address

_____
City, State, Zip

_____ _____
Phone Fax

**Please release the following information:**

- ☐ Problem List
- ☐ Progress Notes
- ☐ History & Physical Exam
- ☐ Immunizations
- ☐ Other Diagnostic Reports (Specify) _____
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ EKG Reports
- ☐ HIV/AIDS Test
- ☐ Mental Health
- ☐ Drug/Alcohol
- ☐ Lab Reports
- ☐ Medications
- ☐ Other Specify
- ☐ Outside records

**This Information is necessary for the following purpose:**

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

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 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 copy 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.

3. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that information released to Austin Regional Clinic may be subject to re-disclosure and may no longer be protected by federal and state privacy regulations. I understand that this authorization shall remain effective indefinitely unless otherwise stated _____ (Date of Expiration), except to the extent that action has been taken in reliance on this authorization, by providing written notice to ARC addressed to:

**Privacy Officer**
4515 Seton Center Parkway, Ste 215
Austin, Texas 78759

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness