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

MRN _____

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_____ Soc. Sec. No._____

City_____ State_____ Zip_____ Telephone #_____

Date of Service_____

Information May Be Released To:

Austin Regional Clinic

Address_____

City/State/Zip_____

From:

Medical Practice/Doctor:_____

Address_____

City/State/Zip_____

Please release the following information:

_____Problem List	_____X-Ray Reports	_____Mental Health	_____ Other Specify
_____Progress Notes	_____X-Ray Films	_____Drug/Alcohol	_____ Outside records
_____History & Physical Exam	_____EKG Reports	_____Lab Reports	
_____Immunizations	_____HIV/AIDS Test	_____Medications	

_____Other Diagnostic Reports (Specify)_____

This Information is necessary for the following purpose:

_____Continued Patient Care _____Personal Use _____Attorney/Legal

_____Insurance _____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 where my permanent records are currently stored. 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 revoked, 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 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.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness