

# Memorial Clinical Associates, P.A.

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## Patient Authorization for Release of Health Records

1. I authorize \_\_\_\_\_ (“Provider”) to disclose information from the health records of \_\_\_\_\_ (patient).

Account #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. **The information is to be disclosed to:** \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

I authorize this information to be disclosed in the following ways:

Written/Photocopy/Paper  Fax

**Purpose of the disclosure:**

Patient's request  Other: \_\_\_\_\_

3. **Dates of Treatment:** From: \_\_\_\_\_ To: \_\_\_\_\_

**Specific reports to be disclosed:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Progress Notes   | <input type="checkbox"/> Laboratory Reports     | <input type="checkbox"/> Operative Reports             |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Radiology Reports      | <input type="checkbox"/> Consultation Reports          |
| <input type="checkbox"/> X-ray films or other images  | <input type="checkbox"/> Photographs/Videotapes | <input type="checkbox"/> Records from other facilities |
| <input type="checkbox"/> Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.) |   |  |
| <input type="checkbox"/> Other(Specify): _____  |   |  |

I give specific authorization to disclose the following information:

- |   |  |
|---|--|
| <input type="checkbox"/> HIV test results                         | <input type="checkbox"/> Documentation of AIDS diagnosis             |
| <input type="checkbox"/> Drug and alcohol abuse treatment records | <input type="checkbox"/> Psychiatric/Mental Health treatment records |

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the Provider in writing.

The Provider may not condition the provision of treatment or payment for my care on my signing this authorization. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: \_\_\_\_\_

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

I understand that if my records are released, I may be charged Twenty Five Dollars (\$25.00) for the first twenty-five pages and Fifty Cents (\$0.50) for each page thereafter and Eight Dollars (\$8.00) for each x-ray film plus the cost of mailing, shipping and delivery.

\_\_\_\_\_  
Signature of Patient (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient Representative

\_\_\_\_\_  
Authority of Representative to Act for Patient  
(Relationship to Patient)

Note: Release of Psychotherapy notes requires a separate authorization.