Texas Health Care, P.L.L.C.
1420 8th Avenue, Suite 101
Fort Worth, TX 76104
817-920-0003 • Fax 817-920-0068

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

My signature below gives permission for the following person(s) to pick up articles containing my or my minor child's personal health information such as but not limited to sample medications, correspondence, test orders, medical records, billing records, etc.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.
4. Texas Health Care, P.L.L.C. and its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Signature: _____

Relationship to patient: _____

Date: _____