

Texas Health Care, P.L.L.C.
Fort Worth, Texas 76104

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at _____
in the city of _____ in the state _____ of hereby authorize:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER, OTHER)

Address: _____

City, St., Zip: _____

to disclose the following specific medical information to:

Name: _____ (RELATIONSHIP)

Address: _____

City, St., Zip: _____

from the Health Records of:

Name: _____
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: _____

City, St., Zip: _____

For the purpose of:

My authorization extends only to those data elements/documents initialed below.

- | | | |
|---|---|---|
| <input type="checkbox"/> Statements of charges or payments | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Mental Health and/or alcohol and drug abuse treatment |
| <input type="checkbox"/> Records of visits (all visits) | <input type="checkbox"/> Photographs, videotapes, digital or other images | <input type="checkbox"/> AIDS/Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency) |
| <input type="checkbox"/> Record of visit for a specific date or dates Specific dates include or are limited to: | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Hepatitis Information |
| <input type="checkbox"/> Copies of records or reports provided to the above named (i.e. hospital, lab, clinic) | <input type="checkbox"/> History and Physical Examination | |
| | <input type="checkbox"/> Consultation Reports | |
| | <input type="checkbox"/> All of the above | |
| | <input type="checkbox"/> Other (Must be specific) | |

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. The revocation must be in writing. A revocation form is available from the receptionist.
4. Texas Health Care, P.L.L.C. and its employees, officers, and physicians are hereby released from any legal responsibility and 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.

(PATIENT'S NAME PRINTED) DATE

EXPIRATION DATE (IF OTHER THAN 1 YEAR FROM ABOVE DATE)

PATIENT'S PERSONAL REPRESENTATIVE DATE

WITNESS DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT DATE

WITNESS DATE