**Authorization for Release of Medical Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To release information from the medical records of**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date of birth

**To be released to:**  **Red River Family Practice**

**900 E 30Th Street, Suite 300**

**Austin, Texas 78705**

**Phone: 512-476-6555 Fax: 512-476-5611**

*PLEASE MAIL RECORDS IF OVER 15 PAGES*

**Information to be released**:

\_\_ Healthcare information relating to the following treatment, condition, or date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ All healthcare information

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of release of information**: \_\_\_ Change of physician

\_\_\_ Application for insurance coverage

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information in my health record may include information related to sexually transmitted disease, Aids, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

**\_\_\_ Yes**, I consent to the release of this information \_\_\_ **No**, I do **NOT** consent to the release of this information

I understand that I may revoke this consent at any time except to the extent that action has already taken in reliance to it and that; in any event, this authorization expires automatically ninety (90) days from the date pf signature.

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**Patient or Legal Guardian Signature**: **Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_