AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

City, State, Zip: _____

I hereby authorize the use or disclosure of protected health information as described below.

RELEASE MY MEDICAL RECORDS TO:

- ☐ Hillcroft Medical Clinic, 1429 Highway 6 Suite 303, Sugar Land, TX
- ☐ Other _____ _____ _____

RELEASE MY MEDICAL RECORDS FROM:

- ☐ Hillcroft Medical Clinic, 1429 Highway 6 Suite 303, Sugar Land, TX
- ☐ Other _____ _____ _____

For treatment dates *(required)*: _____

Purpose of Disclosure *(required)*:

- ☐ Continued Care Insurance
- ☐ Attorney/Litigation
- ☐ Disability Services
- ☐ Other *(please specify)*:_____ _____

Specific Information to be Sent *(required)*:

- ☐ Lab/Pathology
- ☐ Consultations
- ☐ Imaging/Radiology
- ☐ Pulmonary Studies
- ☐ Emergency Room
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Physician Orders
- ☐ Discharge Summary
- ☐ All Pertinent Records
- ☐ Operative/Procedure Report
- ☐ Other*(please specify)*:_____
- ☐ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency
- ☐ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency
- ☐ Entire Record ***INCLUDING*** - HIV Testing Only
- ☐ Entire Record ***INCLUDING*** - Chemical Dependency Only

This authorization is for one year after I, or my personal representative, signs this form. I have the right to revoke this authorization in writing at any time to the Privacy Officer, except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damaged resulting from the lawful release of my protected health information.

_____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

If you are a Personal Representative signing on behalf of the patient, please indicate your relation to the patient:

- ☐ Parent
- ☐ Power of Attorney
- ☐ Other:_____
- ☐ Legal Guardian
- ☐ Executor or Personal Representative