



## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

Patient Name: \_\_\_\_\_ Record Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_

**Information Requested:**

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**Purpose of Release:**

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**The Information is to be provided to:**

Name of Person/Organization/Facility: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

1. I understand that this authorization will **expire** on *(insert date)*\_\_\_\_\_.
2. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *(insert name of practice)* in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

\_\_\_\_\_  
Patient's Signature or Patient's Representative Date

\_\_\_\_\_  
Printed Name of Patient's Representative Relationship to Patient

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM**

*Under HIPAA with patients' written request, records must be provided within 30 days of a request.*

*Under House Bill 300 Texas Law with patients written request, records must be provided within 15 days of a request.*

**HIPAA Authorization for Release of Information**

*This form does not constitute legal advice and covers only federal, not state, laws.*

