



# Authorization For Use or Disclosure of Medical Record Information Austin Regional Clinic

Austin Reg Clinic MR #

ARC Location

## Patient Information

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Release Information To

I hereby authorize Austin Regional Clinic (ARC) to release my medical record information to:

- Mail Copies To:     
  Hold for Patient Pick-up     
  Discuss Medical Information With:

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_

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

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

- Purpose of Request:   
 Personal   
 Continuing Care (second opinion or refer to specialist)   
 Insurance   
 Legal
- Transfer out / reason? \_\_\_\_\_   
 Other \_\_\_\_\_

## Information to be Released

- Please provide a 2 year abstract (includes 5 years of diagnostics)  
 Copy fee capped at \$25.00 for a 2 year abstract
- Other - Please be specific, include dates and MD's under comments-  
 Note: You will be invoiced at the allowable TX Statute rate:  
 Texas Statute Copy Fee: \$25.00 for the first 20 pages; \$.50 per page for  
 over 20 pages, plus postage (not to exceed \$ 15.00).

Comments

*ARC does not provide copies of records received for another physician or institution.  
Please request these records directly from the original healthcare provider.*

## Authorization to Release Protected Information

**\*Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

Initial each line below to confirm your choices

- DO     DO NOT want \*Psychiatric Treatment Notes released    \_\_\_\_\_
- DO     DO NOT want information about \*Mental Health released    \_\_\_\_\_
- DO     DO NOT want information about \*HIV Tests & Related Information released    \_\_\_\_\_
- DO     DO NOT want information about \*Alcohol and/or Substance Abuse released    \_\_\_\_\_
- DO     DO NOT want information about \_\_\_\_\_ released    \_\_\_\_\_

Other sensitive information?



Please confirm that you have put a checkmark and initialed ALL the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here

Date Here

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date\*

\_\_\_\_\_  
Parent/Legally Recognized Representative Signature\*\*

\_\_\_\_\_  
Date\*\*

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Know Your Privacy Rights  
Refer to the HIPAA  
"PRIVACY NOTICE"

\*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise: You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that ARC has already completed action on it.

\*\* By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following:

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. ARC will not condition treatment on payment of the provision of this Authorization.