



Authorization for Use of Disclosure of Protected Health Information FROM Austin Regional Clinic ALL sections must be complete to be a valid authorization

Section I – Patient Information:

Patient Legal Name: _____ Date of Birth: _____
Patient Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Alternate Phone: _____

Section II – Release Information to:

I hereby authorize Austin Regional Clinic (ARC), or a business associate working on their behalf, to release my medical record information to**:

Mail Copies to: Electronically Deliver to: Hold for Patient Pickup Discuss Medical Information with:
Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____ Email: _____

Section III – Purpose of Request:

Purpose of Request: Personal Continuing Care (second opinion or refer to specialist) Insurance Legal
Transfer Out (Reason? _____) Other: _____

Section IV – Information to be Released (Mark all that apply):

Service Dates (Optional) from: _____ to: _____ Clinic and/or Physician/Advanced Practice Clinician (Optional): _____
2 year abstract (includes 3-6 months of diagnostics) Progress Notes
Lab Reports Imaging Reports
Current Medications List Problem List
Diagnosis Findings (procedure reports, EKGs, etc) Immunizations
Billing Information All Health Information
Other: _____

Some requests are subject to fees – see ARC Release of Information Fee Explanation

Section V - Authorization to Release Protected Information

Initials are required to release the following information: Mental Health Treatment _____
HIV/AIDS Tests & Related Information* Genetic Testing Information* _____
Hepatitis C Tests & Related Information* Alcohol and/or Substance Abuse Treatment* _____

I specifically authorize ARC to disclose my Protected Health Information as described on this form to the recipients listed above. I understand that when the 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 by state or federal privacy regulations.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms listed above.
If the patient is 18 year of age or older, the patient must sign and date the form.
If the patient is 18 years of age or older but is incapable of signing, a legally authorized substitute may sign and date the form.
If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Patient's Signature _____ Date* _____
Parent/Legally Recognized Representative's Signature _____ Date* _____
Parent/Legally Recognized Representative's Printed Name _____ Relationship to Patient _____

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise: 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.
** The information released pursuant to the Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws.
CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
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