

AUSTIN REGIONAL CLINIC Authorization for Release and Disclosure of Protected Health Information TO Austin Regional Clinic MRN: _

Tel:		Fax:	Fax:	
hereby authorize the Medical	Record Custodian of the office of I	Dr to re	lease information from the medical record of:	
Patient Name		Date of Birth		
Address		Phone		
City	State Zip	Date of Service		
nformation may be released to:		Information will b	Information will be released from:	
Austin Regional Clini	ic /			
Medical Practice / Doctor		Medical Practice /	Medical Practice / Doctor	
ARC Clínic		Address		
Address, City, State, Zip		City, State, Zip		
Phone	Fax	Phone	Fax:	
Please release the follow			. 57.	
☐ Problem List	☐ X-Ray Reports	☐ Mental Health	☐ Outside Records	
☐ Progress Notes	☐ X-Ray Films	☐ Drug/Alcohol	Other (specify):	
☐ History & Physical Exam	☐ EKG Reports	☐ Lab Reports	_ (1 3)	
☐ Immunizations	☐ HIV/AIDS Test	☐ Medications		
☐ Other Diagnostic Reports (s	necify):			
-	ssary for the following purpos	se:		
			□ Attornov/Loggi	
Continued patient care	☐ Personal use		☐ Attorney/Legal	
☐ Insurance	Other (specify			
	n immunodeficiency virus (HIV). It ma		smitted disease, acquired immunodeficiency avioral or mental health services, and treatment	
assure treatment. I underst	and that with certain exceptions I may		this authorization. I need not sign this in order to e used or disclosed. I understand that any tion may not be protected by federal	
been released in response may no longer be protected otherwise stated	to this authorization. I understand that by federal and state privacy regulati (Date o	at information released to Austin Regions. I understand that this authorizati	ation will not apply to information that has already ional Clinic may be subject to re-disclosure and ion shall remain effective indefinitely unless at action has been taken in reliance on this 0, Austin, Texas 78723.	
Signature of Patient or Legal Representative		Date	Date	
Relationship to Patient		Witness	Witness	