AUSTIN REGIONAL CLINIC

Authorization for Release and Disclosure of Protected Health Information TO Austin Regional Clinic

MRN: _____

Tel: | **Fax:**

I hereby authorize the Medical Record Custodian of the office of Dr _____ to release information from the medical record of:

Patient Name	Date of Birth
Address	Phone
City State Zip	Date of Service

Information may be released to:

Austin Regional Clinic /

Medical Practice / Doctor

ARC Clínic

Address, City, State, Zip

Phone Fax

Information will be released from:

Medical Practice / Doctor

Address

City, State, Zip

Phone Fax:

Please release the following information:

☐ 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	_____
☐ Immunizations	☐ HIV/AIDS Test	☐ Medications	_____

☐ Other Diagnostic Reports (specify): _____

This information is necessary for the following purpose:

☐ Continued patient care	☐ Personal use	☐ Attorney/Legal
☐ Insurance	☐ Other (specify): _____	

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
3. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that information released to Austin Regional Clinic may be subject to re-disclosure and may no longer be protected by federal and state privacy regulations. I understand that this authorization shall remain effective indefinitely unless otherwise stated_____(Date of Expiration), except to the extent that action has been taken in reliance on this authorization, by providing written notice to ARC addressed to: Privacy Officer, 6210 E. US HWY 290, Austin, Texas 78723.

Signature of Patient or Legal Representative	Date
Relationship to Patient	Witness