Texas Health Care, P.L.L.C.

923 Pennsylvania Ave., Suite 100 • Fort Worth, Texas 76104

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at _____

in the city of _____ in the state _____ of hereby authorize:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER, OTHER)

Address: _____

City, St., Zip: _____

to disclose the following specific medical information to:

Name: _____ _____
(RELATIONSHIP)

Address: _____

City, St., Zip: _____

from the Health Records of:

Name: _____
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: _____

City, St., Zip: _____

For the purpose of:

My authorization extends only to those data elements/documents initialed below.

___ Statements of charges or payments
___ Records of visits (all visits)
___ Record of visit for a specific date or dates Specific dates include or are limited to:
___ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic)
___ Progress Notes
___ Photographs, videotapes, digital or other images
___ Discharge Summary
___ History and Physical Examination
___ Consultation Reports
___ All of the above
___ Other (Must be specific) _____
___ Mental Health and/or alcohol and drug abuse treatment
___ AIDS/Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency)
___ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form in available from the receptionist.
4. Texas Health Care, P.L.L.C. and its employees, officers, and physicians are hereby released from any legal responsibility and liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

(PATIENT'S NAME PRINTED) DATE	PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)
EXPIRATION DATE (IF OTHER THAN 1 YEAR FROM ABOVE DATE)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
PATIENT'S PERSONAL REPRESENTATIVE DATE	PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT DATE
WITNESS DATE	WITNESS DATE