AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Other Names Used: _____

Date of Birth: _____ Social Security Number (Last 4 digits): _____

PATIENT INFORMATION IS NEEDED FOR: (Please select one option.)			
□ Continuing Medical Care	□ Military	□ Personal Use	□ School
□ Insurance	□ Legal Purposes	□ Social Security/Disability	
□ Other: (Please specify)			

I hereby authorize T & R Clinic, P.A to

□Release information **TO** or □Obtain information **FROM**

(Please mark a box above)

Provider or Organization: _____

Address: _____ City, State, & Zip: Code: _____

Phone #: _____ Fax #: _____

REQUESTING MEDICAL RECORDS FOR DATES OF SERVICE. (Please select one option.)
□ 1 year □ 2 years □ 3 years
□ Specify Date Range: (Enter Date) _____ -Through- (Enter Date) _____

INFORMATION TO BE RELEASED OR ACCESSED: (Please select one option.)		
□ **All health information History/Physical Exam**		□ Immunization Records
□ Past/Present Medications	□ Lab Results	□ Patient Allergies
□ Operative Reports	□ Consultation Reports/Progress Notes	□ Radiology Reports & Images
□ Discharge Summary	□ Diagnostic Test Reports	□ EKG/Cardiology Reports
□ Pathology Reports	□ Billing Information	□Other- (Please specify)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable disease including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Administrative Code rule 165.2. I hereby release T & R Clinic, P.A. staff, practitioners, physicians, and associates from all liability for fulfilling the authorization request for release of medical information. I understand this authorization will expire ninety (90) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows: _____

Signature of Patient or Legal Representative: _____ **Date:** _____

If signed by legal representative:

Relationship to Patient (Authority to act on patient's behalf): _____

PROHIBITION OF DISCLOSURE: This information has been disclosed to you form the records of a T & R Clinic, P.A. patient whose confidentiality is protected by law. Any further disclosure is strictly prohibited.