Memorial Clinical Associates, P.A.

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Patient Authorization for Release of Health Records

1. I authorize____ ("Provider")
   to disclose information from the health records of____________________________ (patient).
   Account #: __________________ Date of Birth: ____________________
2. **The information is to be disclosed to:** ____________________________
   Address: ________________________
   City, State, Zip: ____________________________________
   Contact Person: ____________________________________
   Phone/Fax: ______________________________________

   I authorize this information to be disclosed in the following ways:
   - ☐ Written/Photocopy/Paper
   - ☐ Fax

   Purpose of the disclosure:
   - ☐ Patient's request
   - ☐ Other:________________________

3. **Dates of Treatment:** From: __________________ To: __________________

   Specific reports to be disclosed:
   - ☐ Progress Notes
   - ☐ Laboratory Reports
   - ☐ Operative Reports
   - ☐ Discharge Summary
   - ☐ Radiology Reports
   - ☐ Consultation Reports
   - ☐ X-ray films or other images
   - ☐ Photographs/Videotapes
   - ☐ Records from other facilities
   - ☐ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   - ☐ Other(Specify):____

   I give specific authorization to disclose the following information:
   - ☐ HIV test results
   - ☐ Documentation of AIDS diagnosis
   - ☐ Drug and alcohol abuse treatment records
   - ☐ Psychiatric/Mental Health treatment records

   I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the Provider in writing.

   The Provider may not condition the provision of treatment or payment for my care on my signing this authorization. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

   Unless revoked earlier, this authorization expires in one year unless I specify another time: __________________

   I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

   I understand that if my records are released, I may be charged Twenty Five Dollars ($25.00) for the first twenty-five pages and Fifty Cents ($0.50) for each page thereafter and Eight Dollars ($8.00) for each x-ray film plus the cost of mailing, shipping and delivery.

____
Signature of Patient (or Patient Representative)

____
Date

____
Printed Name of Patient or Patient Representative

____
Authority of Representative to Act for Patient
(Relationship to Patient)

Note: Release of Psychotherapy notes requires a separate authorization.