Lubbock PRIMARY CARE VIP Medicine

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____ Social Security Number: _____ (optional)

I authorize the following individual or organization to disclose the above named indivdual's health information:

_____ Address: _____

The information may be disclosed to and used by the following individual or organization:

_____ Address: _____

For the purpose of: _____

Please release the following:

☐ Problem List
☐ Progress Notes
☐ History/Physical Exam
☐ Medication List
☐ Immunization Record
☐ List of Allergies
☐ All Records
☐ X-ray/Imaging Reports - from (date)_____ to (date) _____
☐ X-ray films
☐ Laboratory Results - from (date) _____ to (date) _____
☐ EKG Reports
☐ Genetic Testing Information
☐ Other Diagnosis Reports (Please Specify) _____
☐ Other (Please Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, and 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.

☐ **YES, I consent to the release of this information** ☐ **NO, I do not consent to the release of this information**

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition above, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact Lubbock Primary Care at (806)701-4040.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Relationship to Patient (*if legal representative*) **Date**

_____ _____

Witness **Date**

Date request completed: _____ # of pages copied: _____

Charges: $_____ Cash: _____ Check #: _____ Credit Card: _____ Initials: _____