Authorization for Release of Patient Information

Patient Legal Name: | **Date of Birth:** | **Phone:**

Patient Address:

❑ From ❑ To

Total Primary Care

Phone: (512) 866-3018
Fax: (512) 782-9316

City / State / Zip:

❑ From ❑ To

Name:

Address:

City / State / Zip:

Phone:

Fax:

Please check information to be released:

- ❑ ALL MEDICAL RECORDS
- ❑ Lab Results
- ❑ Billing Records
- ❑ Alcohol & Drug Results _____ *Initial*
- ❑ HIV Test Results _____ *Initial*
- ❑ Mental Health Notes _____ *Initial*
- ❑ Other: _____

Purpose for release of information:

- ❑ Personal
- ❑ Legal
- ❑ Insurance
- ❑ Continuing Care
- ❑ Transfer Out (Reason? _____)
- ❑ Other: _____

Preferred Method of receival:

- ❑ Pick up
- ❑ Mail
- ❑ Fax
- ❑ Patient Portal
- ❑ Email: _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken before receipt of revocation. This authorization automatically expires one hundred eighty days (180) from the date of signature or as otherwise specified. I understand that I may be charged a cost-based fee for copies of my medical records in accordance with HIPAA regulations. I understand that these records are protected under federal/state law and cannot be disclosed without my consent unless provided by law. The releasing office will not be responsible for dissemination or disclosure of your confidential medical information once such information is provided, at your request, to your health insurer, employer, attorney, or other designee.

Patient signature: | **Date:**

Parent/Legally Recognized Representative name/signature: | **Date:**