Authorization for Release of Patient's Protected Health Information (PHI)

I hereby authorize____ to release records information on:
Name of provider

Patient name: ____ DOB___________________ Phone: _____________________

For healthcare covering the date from: __________________________To:__________________________

Please release records to:

YOUR HEALTHCARE PLACE
1813 Hinkle Dr Suite 100
Denton, TX 76201
Phone: (940) 312-7266 • Fax: (940) 312-7268

INFORMATION TO BE DISCLOSED:

☐ All health records

☐ Laboratory test

☐ Progress notes

☐ Diagnostic test

☐ Other _________________________________

PURPOSE OF THIS DISCLOSURE IS FOR:

☐ Continuance of medical care

☐ Other__________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, 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 as a result of this authorization maybe subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this authorization maybe revoked in writing at any time. I understand the revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire 12 months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provide a copy of this authorization upon request.

I understand and agree that my medical records will be maintained in an electronic medical record (EMR) format and then records may be transmitted electronically via fax, e-mail, Internet, I'm data transfer system.

I understand that YOUR HEALTHCARE PLACE cannot require me to sign this authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact YOUR HEALTHCARE PLACE.

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Signature of Patient/Legally Authorized Representative Date