

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

OBTAIN Medical Records FROM:
☐ Well Life Family Medicine (as below)

or

☐ _____
Doctor/Hospital

Street Address

City, State, Zip Code

Phone Number

Fax Number

SEND Medical Records TO:
☐ Well Life Family Medicine (as below)

or

☐ _____
Name of Company/Agency/Facility/Person/Medical Provider

Street Address

City, State, Zip Code

Phone Number

Fax Number

Patient Information

Print Patient's Full Name

Date of Birth (Month/Day/Year)

Daytime Phone Number

Street Address

City, State, Zip Code

Purpose of Disclosure

___ Ongoing Treatment

___ Referral to Specialist

___ Legal Investigation

___ Insurance/Workers Comp

___ Transfer of Care

___ Personal

___ Disability Determination

___ Other _____

**I understand there is a charge for copies, as permitted by Texas law, unless copies are sent directly to another healthcare provider.

Information to be Released

Please release the following information for these treatment dates: _____

☐ **Complete Record** or as indicated below:

___ Office Notes/Treatment

___ X-ray and Lab Results

___ Immunization Records

___ Consultation Reports

___ History and Physical

___ EKG/EEG/EMG Reports

___ Medication Records

___ Psychiatric/Psychological Eval.

___ Discharge Summary

___ Pathology Report

___ Operative Report

___ Emergency Room Records

Specific Consent to Release the Following Information if Applicable

___ I do ___ I do not authorize the disclosure of **substance abuse program information** contained in my medical records.

___ I do ___ I do not authorize the disclosure of **mental health facility information** contained in my medical records.

___ I do ___ I do not authorize the disclosure of **HIV (Human Immunodeficiency Virus) information** contained in my medical

records. (Check this box if you wish this authorization to include the disclosure of HIV test results and medical records containing information related to HIV infection status or AIDS (Acquired Immune Deficiency Syndrome). If you check this box, you should understand that persons who have disclosed HIV information have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.)

Patient Rights

1. I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the healthcare provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or my eligibility for benefits will not be affected if I do not sign this authorization.
3. Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by these regulations.
4. My record may contain information that only a physician can interpret. I will not hold Well Life Family Medicine liable for any misinterpretation of information if I fail to contact my physician for clarification.
5. I am entitled to receive a copy of this signed authorization.

This authorization is effective until: _____ (date not to exceed one (1) year). The one year limit applies to records dated on or before the date indicated below. Records created after this date requires a new authorization form.

Patient or Legal Representative Signature

Date

Printed Name of Patient or Legal Representative

Relationship (Self/Parent/Legal Representative)