# Authorization to Release Medical Information

_____ _____/_____/_____
Patient Name (Print) Patient Date of Birth

I authorize _____ to use or release/disclose my health information as described below. (In blank space please print previous doctor's name and phone number.)

Please identify the information to be released:

- ☐ Please release my entire record

  -OR-

- ☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated)
  - o Problem List
  - o Medication List
  - o List of allergies
  - o Immunization records
  - o Most recent history
  - o Most recent discharge summary
  - o Lab results (please describe the date or types of lab tests you would like disclosed):_____
  - o X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):_____
  - o Consultation report (please supply doctors' names):_____
  - o Other (please describe):_____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe):_____

Please initial each item below to indicate your understanding.

_____ I understand 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 or drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following organization: (If over 25 pages please mail records.)

**The Children's Clinic**
**3435 S Alameda**
**Corpus Christi, TX 78411**
**Attn: Medical Records**
**Phone: 361-855-7346 x 177 Fax: 361-654-7197 Email: Chris@thechildrensclinic.com**

This authorization will expire on (insert date or event):_____. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____/_____/_____
Patient Signature (or signature of person completing form if not Patient*) Date
*Relationship to patient: _____Parent _____ Legal Guardian _____ other: _____

_____ _____/_____/_____
Witness Signature Date