HEALTHTEXAS
PRIMARY CARE DOCTORS

Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____
Street Address: _____ City/State/Zip: _____
Cell Phone: _____ Home (Landline): _____

DISCLOSE / SHARE MY MEDICAL RECORDS FROM:

Person / Organization: _____
Address (Street / City / State / Zip): _____

_____

Phone: _____ **Fax:** _____

DISCLOSE / SHARE MY MEDICAL RECORDS TO:

Person / Organization: _____
Address (Street / City / State / Zip): _____

_____

Phone: _____ **Fax:** _____

REASON FOR DISCLOSURE
- ☐ Treatment / continuing care
- ☐ Personal use
- ☐ Billing or claims
- ☐ Legal purposes
- ☐ Insurance / disability
- ☐ Email
- ☐ Other:

Box 1

WHAT INFORMATION CAN BE DISCLOSED? Please mark all that apply

Date Range, if applicable: _____

☐ All Health Information	☐ Visit Summary or Consultation Notes	☐ Billing Information	☐ Lab, Imaging or Diagnostic Test Results

Initial below to consent to releasing any of the following information:

___ Mental Health Records (excluding psychotherapy notes)
___ Drug, Alcohol, or Substance Abuse Records
___ Genetic Information (including Genetic Test Results)
___ HIV/AIDS Test Results/Treatments

I freely authorize the named person/organization to release my medical records to the named person/organization with the understanding that:

- A photocopy or fax of this authorization is as valid as this original.
- I may revoke this authorization at any time in writing, except where information has already been released.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
- I do not need to sign this form in order to ensure healthcare treatment, payment, enrollment or eligibility.

_____ _____
Signature of the patient or parent / legal guardian Date

_____ _____
Relationship to the patient[1] Expiration date of authorization[2]

1. If you are a guardian or court-appointed representative, you must attach a copy of your legal authorization to represent the patient, except in the case of the parent of a minor patient. 2. Unless noted, authorization expires 10 years from date of signature above.

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OPTIONAL: PATIENT AGREES TO SHARE/DISCLOSE MEDICAL RECORDS IN A MANNER IDENTICAL TO THE PARTY LISTED IN BOX 1 WITH PERSONS LISTED BELOW

DISCLOSE / SHARE MY MEDICAL RECORDS / INFORMATION FROM:

Person / Organization: HealthTexas Medical Group
Address (Street / City / State / Zip): ____________________

____

Phone: ____________ **Fax:** ____________

DISCLOSE / SHARE MY MEDICAL RECORDS / INFORMATION TO:

Person / Organization: ____________________
Address (Street / City / State / Zip): ____________________

____

Phone: ____________ **Fax:** ____________

REASON FOR DISCLOSURE
- ☐ Treatment / continuing care
- ☐ Personal use
- ☐ Billing or claims
- ☐ Legal purposes
- ☐ Insurance / disability
- ☐ Email
- ☐ Other:

DISCLOSE / SHARE MY MEDICAL RECORDS / INFORMATION FROM:

Person / Organization: HealthTexas Medical Group
Address (Street / City / State / Zip): ____________________

____

Phone: ____________ **Fax:** ____________

DISCLOSE / SHARE MY MEDICAL RECORDS / INFORMATION TO:

Person / Organization: ____________________
Address (Street / City / State / Zip): ____________________

____

Phone: ____________ **Fax:** ____________

REASON FOR DISCLOSURE
- ☐ Treatment / continuing care
- ☐ Personal use
- ☐ Billing or claims
- ☐ Legal purposes
- ☐ Insurance / disability
- ☐ Email
- ☐ Other:

DISCLOSE / SHARE MY MEDICAL RECORDS / INFORMATION FROM:

Person / Organization: HealthTexas Medical Group
Address (Street / City / State / Zip): ____________________

____

Phone: ____________ **Fax:** ____________

DISCLOSE / SHARE MY MEDICAL RECORDS / INFORMATION TO:

Person / Organization: ____________________
Address (Street / City / State / Zip): ____________________

____

Phone: ____________ **Fax:** ____________

REASON FOR DISCLOSURE
- ☐ Treatment / continuing care
- ☐ Personal use
- ☐ Billing or claims
- ☐ Legal purposes
- ☐ Insurance / disability
- ☐ Email
- ☐ Other:

Box 2