Authorization to Release Protected Health Information

Patient Name: _____Birthdate:_____

Mailing Address:_____

Phone:_____ SS#:_____

I HEREBY AUTHORIZE *MAGNOLIA FAMILY MEDICINE* TO RELEASE MY MEDICAL RECORDS TO THE ADDRESS OR FAX NUMBER BELOW:

FROM:

Magnolia Family Medicine

6912 FM 1488, Suite A

Magnolia, Texas 77354

P: 281-356-1945

F: 281-356-1978

TO:

Doctor's name or facility:_____

Address:_____

_____

P:_____

F:_____

Please specify dates(s) **MUST BE COMPLETED**

Treatment Dates:_____

Circle reason(s): **Medical Care** **Legal** **Insurance** **Other**

- ☐ Office Visit Progress Note
- ☐ Immunizations
- ☐ EKG
- ☐ Lab
- ☐ Imaging/Radiology
- ☐ MD Orders
- ☐ Registrations Summary
- ☐ Entire Records
- ☐ Entire Record Excluding HIV & Chemical Dependency
- ☐ Entire Record Including HIV & Chemical Dependency
- ☐ Entire Record Including HIV Testing Only
- ☐ Entire Record Including Chemical Dependency only
- ☐ Other_____

This authorization is valid until the 180th day after the date is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked and cover only treatment(s) for the dates specified above.

_____(initials) I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, and/or AIDS information. I understand, have read the above and authorize the above authorized staff to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above-named facility and its parent company from all liability and damages resulting from a lawful release of my Protected Health Information.

_____ _____

Name of Patient/Parent/Conservator/Guardian Authority/Relationship to Patient

_____ _____

Signature of Patient/Parent/Conservator/Guardian Date