Authorization for Release of Medical Information

Date: _____

I hereby authorize:

Central Family Practice
720 W. 34th Street, Suite 105
Austin, TX 78705
Phone: 512.371.9260
Fax: 512.371.9550

To release information from the medical records of:

_____	_____	_____
Patient Name	**Date of Birth**	**Social Security No.**

To be released to: _____

_____

_____

Information to be released:

- ☐ **History & Physical**
- ☐ **Laboratory**
- ☐ **X-Rays**
- ☐ **Other** _____
- ☐ **Consultation**
- ☐ **EKG**
- ☐ **Progress Notes**

Date(s) of treatment to be released: _____

I understand that the information in my health record may include information related to sexually transmitted disease, Aids, or 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 release of this information

Purpose of release of information:

- ☐ **Change of Physicians**
- ☐ **Application for Insurance Coverage**
- ☐ **Other:** _____

(A "reason or purpose of release" is required by Texas law.)

There is a minimum charge of $25.00 for copying medical records requested by patients.

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance to it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient or Legal Guardian Signature **Date**

_____ _____