Well Life
FAMILY MEDICINE

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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)