Plano Primary Care Clinic

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of the following individual's health information to be released as described below.

Patient Name:_____ Date of Birth: ___/___/_____

Address:_____ Phone: _____

City, Sate, Zip: _____

I request the following individual or organization to release the health record.

(**TO** or **FROM**- circle one)

Entity's Name:_____ Phone: _____

Address:_____ Fax: _____

City, Sate, Zip: _____

Information to be released:

____Complete Health Record ____Lab Reports ____X-Ray Reports

____Pathology Reports ____Progress Notes ____Other: _____

Purpose of Release:

_____

Specific authorization is given for release of information concerning alcohol or substance abuse, psychiatric information, and/or sexually transmitted diseases included but not restricted to HIV or testing for such conditions or diseases.

Signature: _____ Date: _____

(Patient or Legal Guardian)

I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon prior to revocation) at any time by written, dated communication. If revocation is not received, authorization will be considered valid for a period of 90 days. I understand that there is a charge for transfer of records, not to exceed $25.00 for the first 20 pages, 15 cents a page for other pages, plus the cost of postage.

This facility, its employees, officers, and attending physician(s) are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Printed Name of Patient or Legal Guardian: _____

Signature: _____ **Date:** _____

(Patient or Legal Guardian)

Signature of Witness: _____ **Date:** _____