TEXAS PARTNERS HEALTHCARE GROUP

Consent/Authorization for Release of Information

1. I hereby authorize:

   Name: _____Address:_____

   City: _____ State: _____Zip:_____

   Phone: _____Fax:_____

   To release the following information from the health record(s) of

   Patient's Name: _____

   Phone Number: _____ Date of Birth: _____

   Covering the period(s) of treatment: From: _____ To: _____

2. Information to be released:

   ☐ Progress Note — Mail Copies: _____

   ☐ Radiology — Patient Pick-Up: _____

   ☐ Billing Records — Faxed: _____

   ☐ X-Ray Films

   ☐ Complete Medical Record (includes information regarding insurance, demographic, referral documents and records)

3. Information is to be released to:

   Name: _____Address:_____

   City: _____ State: _____Zip:_____

   Phone: _____Fax:_____

   Purpose of disclosure: Treatment Payment Healthcare Operations Other

4. I understand that I may revoke this consent/authorization at any time by notifying Texas Partners Healthcare Group in writing.

   I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

5. **This authorization will remain in effect until revoked by me in writing.**
6. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.
7. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

*There is a $25.00 fee for the first 20 pages, and $.50 cents per each additional page when applicable.

Please allow two weeks notice for releases.

Signature: _____ Date: _____

Witness: _____ Relationship:_____