General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____
Address: _____
Phone: _____
SSN: _____ Date of Birth: ____/____/____

Facility/Doctors Name: _____ Phone: _____

Fax: _____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

All records	Laboratory/pathology records
X-ray/radiology records	Billing records
Abstract/Summary	Pharmacy/prescription records
Other (describe specifically) _____	

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____ to _____

Please send the records listed above to:

FAMILY PRACTICE DOCTORS
1485 FM 1960 Bypass Rd. E. Suite 100, Humble, TX 77338
Tel: 281-570-2606
Fax: 281-570-2611

I understand that this authorization may be revoked in writing at any time, except to the event that action has already been taken in reliance on this authorization. I understand that this authorization will expire on ____/____/____ (6 months from the date this form is signed, or a lesser period of time if so requested by the patient).

The information may be used/disclosed for each of the following purposes:

*At my request	*For my health care
*For payment/insurance	*For employment purposes
*As written by state law	* If urgently needed for the patient's continued care

If this disclosure contains information relating to HIV, Behavioral Health, Alcohol or Drug Abuse education, training, treatment, rehabilitation, or research, the following shall apply:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____
Printed name of patient representative Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Family Practice Doctors at 1485 FM 1960 Bypass Rd. E. Suite 100, Humble, TX 77338.