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PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ Date of Birth: ________________________

Address: ____ Phone:______________________________

I hereby authorize the Facility/Provider:

Name: ____ Phone:______________________________

Address: ____

To release the following information contained in my medical records to Springtown Family Health Center for the period:

From: ____________________________ to ________________________________

All PHI including confidential / all PHI except confidential selected below

(Note: While specific confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)

Confidential:

- HIV Test Results
- Alcohol & Drug Therapy
- Medical/Mental Health Treatment Records
- Clinic Notes for Doctors
- Lab Reports
- X-Ray Reports
- Other: (please specify) ____

Release of PHI is for:

ALL MEDICAL RECORDS OR **OTHER**: ____

IF YOU ARE SENDING MORE THAN 25 PAGES, PLEASE MAIL/EMAIL THE MEDICAL RECORDS

Springtown Family Health Center
inbox@springtownclinic.com
PO BOX 1039, Springtown, TX 76082

This is:

- A one-time disclosure
- A continuing disclosure for 12 months

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. Unless I otherwise revoke this authorization in writing it shall expire on the following date, event or condition:____. At that time no express revocation shall be needed to terminate my authorization. I hereby release any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.

Patient Signature:____ Date Signed:_____________________

Relationship to patient (if applicable):____

Signature of witness (if needed):____