PATIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Blanco Regional Clinic, PA

830-833-5581 office 830-833-4933 fax

____________________________________ ____________ ________________

PATIENT NAME DATE OF BIRTH LAST 4 OF S.S.#

I HEREBY FREELY AND VOLUNTARILY AUTHORIZE BLANCO REGIONAL CLINIC TO OBTAIN RECORDS OF MY HEALTH INFORMATION FROM:

_____________________________ _____________________________________

FACILITY TELEPHONE #

____ _________________________

ADDRESS FAX#

____ _________

CITY, STATE AND ZIP

THE PURPOSE FOR DISCLOSURE:____

PLEASE RELEASE THE FOLLOWING:

________**ENTIRE RECORD** or

__________problem list _____progress notes _______history and pe _______immunization record ________ekg _____x ray _______labs _______hospital ______other____________________

My medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for the health information that is released with my authorization to be re-disclosed by the recipient and to be no longer protected by the Federal HIPAA law.

I understand that I have the right to revoke this authorization at any time by giving written notice to the Blanco Regional Clinic Privacy Officer, except to the extent that Blanco Regional Clinic has already taken action in reliance on it.

_______________________________________ _________________

Patient Signature Date

____________________________________ ________________

Parent Guardian or legal representative Date

____________________________________ ________________

Witness Signature Date