

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ **Date of Birth:** _____ **SS#:** _____

I authorize the following individual or organization to disclose the above named individual's health information:

Goodall-Witcher Clinic in Whitney Address/Phone: 202 E. Jefferson Ave.; Whitney, TX 76692

This information may be disclosed **TO** and used by the following individual or organization:

_____ Address/Phone: _____

For the purpose of: _____

Please release the following:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Medication List
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> List of Allergies	<input type="checkbox"/> X-Ray/Imaging Reports
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Other Diagnostic Reports
<input type="checkbox"/> Other Records (Specify) _____		

This authorization covers the patient care given from _____ to _____
Date Date

I understand that the information released is for the specific purpose stated above. Any other use of the information without the written consent of the patient is prohibited. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months. I understand that disclosing my information is voluntary, that it may contain reports, test results, and notes that only a physician can interpret. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at Goodall-Witcher Clinic in Whitney.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness