CONNECTIONS PRIMARY CARE

2721 Shoreline Drive, Suite 120
Denton, TX. 76210
Phone: 940-205-6584
Fax: 940-324-0633

Website: www.ConnectionsPrimaryCare.com

AUTHORIZATION FOR RELEASE / DISCLOSURE OF PRIVATE HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) identified below.

I authorize my health care information to be released to the following **recipient**(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

☐ At the request of the patient (Note: "at the request of the patient" is sufficient if patient is initiating Authorization)

Information to be disclosed: I authorize the release of the following health information (check the applicable box below):

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

☐ Only the following records or types of health information:

_____.

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20_____.

☐ Until the Provider fulfills this request.

☐ Until the following event occurs:_____

[1] **Note**: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

CONNECTIONS PRIMARY CARE

2721 Shoreline Drive, Suite 120
Denton, TX. 76210
Phone: 940-205-6584
Fax: 940-324-0633

Website: www.ConnectionsPrimaryCare.com

Disclosure: I understand that my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I do not sign, it will not affect the commencement, continuation, or quality of my treatment at Connections Primary Care.

If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Connections Primary Care. The revocation will be effective immediately upon my health care provider's receipt of my written notice. I understand that the revocation will not have any effect on any action already taken by my health care provider before receipt of my written notice of revocation.

_____ _____

Signature Date

_____

Printed Name

_____

Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____

Signature of Guardian / Representative Date

_____ _____

Printed Name of Guardian / Representative Relationship to Patient