AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE THE PROVIDER BELOW TO RELEASE MY MEDICAL RECORDS :

Provider: (name and address)	Patient: SS#: DOB:

✓***Check all that apply*** *RECORDS AUTHORIZED TO BE RELEASED:*

____ All Medical Records	____ Health summary
____ X-ray/radiology records	____ Pharmacy/prescription records
____ Laboratory/pathology reports	____ Billing records
____ Psychiatric/mental health records	____ Drug/alcohol use/abuse
____ HIV (AIDS) test results/information	____ Other (specify):_____

***Note:** When "All Medical Record" status is selected, you are hereby authorizing disclosure any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease*

THESE MEDICAL RECORDS WILL BE USED FOR THE PURPOSE OF:

____ Continuing care	____ Personal copy	____ Insurance claim
____ Legal claim	____ Disability determination	____ Other _____

I AUTHORIZE MY MEDICAL RECORDS TO BE DISCLOSED AND USED BY THE FOLLOWING ORGANIZATION:

SEGUIN FAMILY MEDICINE
515 N. King Street, Suite 103
Seguin, Texas 78155
Phone: 830-372-5200 Fax: 830-372-5202

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. *I also understand that:*

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Seguin Family Medicine may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as the original.

Patient or Representative Signature _____

Patient or Representative (printed) _____

Relationship to Patient _____

Date _____