

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_ Address/Phone: \_\_\_\_\_

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

Goodall-Witcher Clinic in Clifton Address/Phone: 201 Posey Ave., Clifton, TX 76634

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 \_\_\_\_\_

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 the Clifton Medical Clinic.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (If Legal Representative)

\_\_\_\_\_  
Witness