GEORGETOWN MEDICAL CLINIC

3201 South Austin Ave Suite 210 ★ GEORGETOWN TEXAS 78626
Phone 512-763-4000 ** Fax 512-930-4946

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________________

Address: ______________________________ City: ________________ State: _____ Zip: ________________

Telephone#: (____) ________________ SS#: ______________________ (Optional) Treatment Date: ____________

I hereby request and authorize my medical records: Please do not send records on CDs.

Released to: Georgetown Medical Clinic ____________ From: ______________________________

3201 South Austin Ave Suite 210 ______________________________

Georgetown, Texas 78626 ______________________________

This authorization applies to all of the reports checked below:

- ☐ History
- ☐ Care Plans
- ☐ Bone Density Measurements
- ☐ Pulmonary Function Test
- ☐ Health Assessment Questionnaires
- ☐ Physical Examination
- ☐ Electrocardiogram (EKG)
- ☐ Blood Tests
- ☐ Physical Fitness Assessment
- ☐ Progress Notes
- ☐ Exercise Stress Test
- ☐ Urine Tests
- ☐ Complete Medical Records

Purpose of disclosure: (check all that apply)

- ☐ Changing Physicians
- ☐ Moving out of town
- ☐ Changing Insurance
- ☐ other ____

This authorization is valid for ______________ (specify time up to one year) from the date of signature.

Prohibition of Redisclosure

I understand that to the extent any Recipient of this information, as identified above, is not a “covered entity” under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that Georgetown Medical Clinic has already relied on this authorization. I understand that I may revoke this authorization by providing Georgetown Medical Clinic a written request for revocation stating my intent to revoke this authorization.

I understand that Georgetown Medical Clinic may not condition treatment on my completion of this authorization form.

If information is being released directly to me, I understand that my medical record may contain reports, tests results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Georgetown Medical Clinic liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Patient’s Printed Name Identification Number

______________________________ ______________________
Signature of Witness Date