Town & Country Family Physicians
10497 Town and Country Way | Suite 360 | Houston, Texas 77024
Telephone 713.341.2100 opt. 2 | *Facsimile* 713. 932.7072

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Town and Country Family Physicians to disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____ Social Security# _____(optional)

This information may be disclosed TO and used by the following individual or organization:
(The name and address filled in below is where you would like us to send records)

Provider/Practice Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State**: _____ **Zip:** _____

For the purpose of: ☐ Continuation of care ☐ Change of insurance or PCP ☐ Referral ☐ Other: _____

Please release the following: {Note: list not required by HIPAA}

☐ Entire Record
or:
☐ Problem List
☐ Progress Notes
☐ History/Physical Exam
☐ Medication List
☐ Immunization Record
☐ List of Allergies
☐ X-Ray/Imaging Reports-from (date)_____ to (date)_____
☐ Laboratory Results-from (date) _____ to (date) _____
☐ EKG Reports
☐ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
☐ ***Yes**, I consent to the release of this information.* ☐ ***No**, I do not consent to the release of this information.*

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a 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. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____. (MM/DD/YYYY format)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (713) 341-2100 opt. 2.

I understand that there is a fee for preparing and furnishing outgoing medical records.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test 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 contained in these entries. I will not hold Town & Country Family Physicians or my provider individually liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date request completed_____ # pages copied_____ Reviewed only: _____
Charges $_____Cash_____ Check #_____ Initials_____

Medical records will be assessed a charge of $25.00 for the first 20 pages and $.50 cents per page thereafter. There will also be a $25.00 fee for billing records. Also, a reasonable fee not to exceed $15.00 for executing an affidavit. Payment will be required in advance. Please allow fifteen business days for processing.