EAST TEXAS PRIMARY CARE

Medical Record Release

Patient Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize East Texas Primary Care to release my protected health information in the manner listed below to the following recipient:

Send by: (choose ONE): ☐ Mail ☐Fax

Send to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send:

☐ All Records (Notes, Labs, Reports)

Or

☐ Specific Item Only (please list): _____

This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that 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 send my written request to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I understand East Texas Primary Care will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

_____ _____

Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate Date

_____ _____

Printed name Relationship to Patient