



Authorization to Release/Obtain Protected Health Information

Patient Legal Name (Print) Patient Social Security Number Patient DOB

(Initial) I authorize West Frisco Health and Wellness and/or West McKinney Health and Wellness to obtain or disclose my health information as described below.

Please identify the information to be obtained or released (check one option):

Please release my entire record

-OR-

Please release only the following information (check appropriate boxes):

- Problem list
Medication list
List of allergies
Immunization records
Most recent history
Most recent discharge summary
Lab results (please describe the dates or types of lab tests):
Imaging reports (please describe the dates or types of images):
Consultation reports (please provide doctors' names):
Other (please describe):

The identified information will be used for the following purpose (check one option):

- My personal records - pick up in office mail to address on file *fee will be charged*
Sharing with other health care providers as needed
Other (please describe):

Please initial each item below to indicate your understanding.

- I understand 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.
I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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.
I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be obtained from the following doctor/hospital/clinic:

Name: Fax Number: Name: Fax Number:

This authorization will expire on (insert date or event): If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Patient/Legal Representative's Signature Date
Relationship to patient: Self Parent Legal Guardian Other:
Office Staff Signature Date