Arlington Family Practice, 2415 Matlock Rd Arlington TX 76015
Office 817.277.6444 Fax 817.548.7329
Authorization for use and disclosure of protected health information (PHI)

NAME OF PATIENT OR INDIVIDUAL:_____
OTHER NAME(S) USED _____
DATE OF BIRTH: Month _____Day _____Year_____
ADDRESS _____
PHONE (_____) _____ **ALT. PHONE** (_____) _____
Pick up at office _____ Mail _____ Circle: Paper or CD

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:
Person/Organization Name _____
Address _____
Phone (_____) _____Fax (_____) _____
WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Organization Name _____
Address _____
Phone (_____) _____Fax (_____) _____

REASON FOR DISCLOSURE (Choose only one option below) :
___ Treatment/Continuing Medical Care ____ Personal Use ____ Billing or Claims
____ Insurance ___Legal Purposes ____ Disability Determination
___ School ____ Employment ____ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.
____ All health information for the past 3 years ___ **All health information**
____ History/Physical Exam ___ Past/Present Medications ___ Lab Results ____ Pap Results ____ Patient Allergies
___Colonoscopy ____DEXA ____ Consultation Reports ____ Mammogram ____ Radiology Reports
____ Immunizations ____ Laboratory test results ____ Progress note ____ Other _____

Your initials are required to release the following information:
_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month _____ Day _____ Year _____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____
Signature of Individual or Individual's Legally Authorized Representative **Date**
Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ___ Parent of minor ____Guardian ___Other
_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam.Code § 32.003).
SIGNATURE X_____
Signature of Minor Individual **Date**

Employee initial/date: _____