

AUTHORIZATION FOR RELEASE OF INFORMATION
THIS REQUEST MUST BE FILLED OUT COMPLETELY

Patient's Name: _____ SS# _____ DOB: _____

Address: _____

I authorize Amarillo Diagnostic Clinic to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. 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 the federal and state privacy regulations. I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Information to be released TO:

FROM: _____
Name of physician(s)
Amarillo Diagnostic Clinic, P.A.
6700 W. Ninth
Amarillo, TX 79106-1701
(806) 358-0200

Information to be released: (Check all that apply)

_____ History/Physical Exam Notes
Dates: _____
_____ Laboratory Results
Dates: _____
_____ X-Ray Reports
Dates: _____

_____ Other Diagnostic Reports
Dates: _____
_____ Other (Please specify)

Reason or Purpose for Release: (Check the appropriate category)

_____ Continued Patient Care
_____ Insurance Claim/Application
_____ Attorney/Legal
_____ Personal Use
_____ Disability Determination/Social Security
_____ Other (Specify) _____

I understand that the information released is for specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the date of my signature unless otherwise specified.

Signature of Patient or Patient's Legal Representative
(Please attach supporting documentation for legal representative)

Date

-----For Office Use Only-----

Records picked up _____ Records sent _____

Date _____ Initials _____