AUTHORIZATION FOR RELEASE OF INFORMATION

THIS REQUEST MUST BE FILLED OUT COMPLETELY

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

Address: _____

I authorize _____ 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 FROM:

_____
_____
_____
_____

TO: Dr. Joanna Wilson
Freida Toler, FNP
Amarillo Diagnostic Clinic
6700 W. 9th
Amarillo, TX 79106-1701
(806) 358-0200
(806) 356-5590 (Fax)

Information to be released: (Check all that apply)

____ History/Physical Exam Notes
____ Laboratory Results
____ X-Ray Reports
____ Diagnostic Reports
____ Other (Please specify)
_____
_____

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

____ Continued Patient Care
____ Insurance Claim/Application
____ Attorney/Legal
_____ Personal Use
_____ Disability Determination
_____ 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 Legal Representative **Date**