



# GEORGETOWN MEDICAL CENTER CLINIC

2100 SCENIC DRIVE [ GEORGETOWN TEXAS 78626

## AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone#: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_ (Optional) Treatment Date: \_\_\_\_\_

I hereby request and authorize my medical records:

Released to: \_\_\_\_\_ From: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### This authorization applies to all of the reports checked below:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> History                          | <input type="checkbox"/> Physical Examination        | <input type="checkbox"/> Progress Notes       |
| <input type="checkbox"/> Care Plans                       | <input type="checkbox"/> Electrocardiogram (EKG)     | <input type="checkbox"/> Exercise Stress Test |
| <input type="checkbox"/> Bone Density Measurements        | <input type="checkbox"/> Blood Tests                 | <input type="checkbox"/> Urine Tests          |
| <input type="checkbox"/> Pulmonary Function Test          | <input type="checkbox"/> Physical Fitness Assessment |   |
| <input type="checkbox"/> Health Assessment Questionnaires |  |   |

### Purpose of disclosure: (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Changing Physicians | <input type="checkbox"/> Moving out of town | <input type="checkbox"/> Changing Insurance |
| <input type="checkbox"/> Other _____         |   |   |

This authorization is valid for \_\_\_\_\_ (specify time up to one year) from the date of signature.

### Prohibition of Redislosure

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that Georgetown Medical Center Clinic has already relied on this authorization. I understand that I may revoke this authorization by providing Georgetown Medical Center Clinic a written request for revocation stating my intent to revoke this authorization.

I understand that Georgetown Medical Center Clinic may not condition treatment on my completion of this authorization form.

If information is being released directly to me, I understand that my medical record may contain reports, tests results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Georgetown Medical Center Clinic liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Identification Number

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date