



181 Town Center Blvd. Ste. 300
Jarrell, Texas 76537
PH: 512-746-2690 Fax: 888-254-4802

AUTHORIZATION TO ACCESS OR RELEASE MEDICAL INFORMATION

Patient Name

Date of Birth

Address

City, State Zip

Phone number

Social Security #

___ I request that Your Personal MD release my records to the following person or facility:

___ I request that the facility below release my records to Your Personal MD:

Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Include this information (if applicable): ___ Alcohol/Drug ___ HIV/AIDS ___ Genetics ___ Mental Health

___ Limit to records regarding specific illness/injury/mental health (condition and/or approximate dates):

___ All Medical Records ___ Immunization Record ___ Lab Reports ___ X-ray/Imaging Reports

___ Summary information (Clinic notes, history & physical, operative reports, pathology reports, consults.)

PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE(S):

___ Continued Care ___ Insurance ___ Personal Use ___ Attorney/Legal

I have read and understood the following terms and conditions of this request:

- I understand authorizing the use or disclosure of the information listed above is voluntary and I am not required to sign this authorization to obtain treatment at Uncommon Healthcare.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to re-disclosure by the recipient.
- I may revoke this authorization, in writing at any time except to the extent Uncommon Healthcare has already relied on this authorization.
- My record may contain information that only a physician can interpret. I will contact my physician if I have a question about my diagnosis or treatment. I will not hold Uncommon Healthcare liable for any misinterpretation of information if I fail to contact my physician for clarification.

This authorization will expire in 180 days or at the date specified here: _____ (initial here)

Signature of Patient or Legal Representative

Relationship to Patient

Date