COLEMAN MEDICAL ASSOCIATES

PO Box 312
Coleman, TX 76834
(325) 625-3533, Fax (325) 625-3477

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
(First) (Middle) (Last) (Previous Name)

Address: _____

Date of Birth: _____ Social Security Number: _____

Phone: _____ My Physician at Coleman Medical Associates is: _____

Release Records **From** Coleman Medical Associates **To:**		Release Records **To** Coleman Medical Associates **From:**
(Name)		(Name)
(Address)	**OR**	(Address)
(City) (State) (Zip)		(City) (State) (Zip)
(Phone Number) (Fax Number)		(Phone Number) (Fax Number)

Reason for record request: _____

IMPORTANT – You may disclose health care Information regarding testing, diagnosis, and Treatment for (check yes or no):

( ) Yes ( ) No HIV (AIDS virus)
( ) Yes ( ) No Sexually transmitted diseases
( ) Yes ( ) No Psychiatric disorders/mental health
( ) Yes ( ) No Drug and/or alcohol use

Information to be released (be specific):

( ) Last 2 years of records
( ) Last 5 years of records
( ) X-ray (specific dates) _____
( ) Only dates of service from _____ to _____
( ) Other records (specify) _____

This authorization expires within 90 days of being signed. If you wish to have the authorization expire before 90 days please indicate the date of expiration: _____

I understand I do no have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign and authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already take by Coleman Medical Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Coleman Medical Associates, or
- Write a letter to Coleman Medical Associates.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____
Patient or legally authorized individual signature Date Time

_____
Printed name if signed on behalf of the patient Relationship (parent or legal representative)

OFFICE USE ONLY Date received: Date released: Staff initials sent by: