MEMORIAL HOSPITAL
SEMINOLE HOSPITAL DISTRICT

# SEMINOLE FAMILY MEDICAL CLINIC
207 NW 8th St (3RD FLOOR)
Seminole, Texas 79360

## *AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION*

Patients Name: _____ DOB: _____

Home #: _____ Work#: _____

Address: _____ City/St./ZIP: _____

***Please Note: Copy Fee May Be Charged for Medical Records***

***Labs, X-ray results, etc. must be requested from Hospital Medical Records at Phone #432-758-4883 fax #432-758-4742**

**Above listed patient authorizes the following healthcare facility to make record disclosure:**

Facility Name: _____ Facility #: _____

Facility Address: _____ Facility Fax #: _____

City/ST/ZIP: _____

**Dates and Type of information to disclose:**

- ☐ 2 years prior from last date seen
- ☐ Dates other: _____
- ☐ Specific Information Request: _____

**Purpose of disclosure is:**

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (Please send last 2 years, Labs, Radiology and/ or any other testing done)
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the releases of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

**This information may be disclosed and used by the following individual or organization:**

Release to: _____ _____ Address: _____

Office #: _____ Fax #: _____

☐ **Please fax medical records. Over 20 pages please mail.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and presenting written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.
I understand that authorization the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I have read the above foregoing Authorization for Release of information and do herby acknowledge that I am familiar with and fully understand the terms and conditions for the authorization.

X _____ _____
Signature of Patient / Parent/ Guardian / AR Date