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PATIENT AUTHORIZATION FOR RELEASE OF HEALTH RECORDS TO EXTERNAL PARTIES

1. **I authorize _____*(Physician/Hospital)* of _____ *(City)* to disclose**

   information from the health records of: _____ _____
   (Patient) ***(Date of Birth)***

2. **The information is to be disclosed to Family First Clinic and Urgent Care of Jacksonville.**
3. **Specific reports to be disclosed:**

☐ **Entire Health Record (including but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records form other facilities)**

☐ **Other (Specify): _____**

I give specific authorization to disclose the following information:

___ HIV test results **___ Documentation of AIDS diagnosis**

___ Drug and alcohol abuse treatment records **___ Psychiatric/Mental Health treatment records**

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke authorization by notifying Family First Clinic and Urgent Care in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal of Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I relaease the individual or organization named in the authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) **Date**

_____ _____
Printed Name of Patient or Patient Representative **Authority of Representative to Act for Patient (Relationship to Patient)**