TOLEDO BEND FAMILY MEDICINE

2421 Worth Street Hemphill, TX 75948

Phone: (409) 787-1416 Fax: (409) 787-1419

**** We cannot accept medical records on a disk ****

( ) request from individual for Hospital Records (applicable fees apply)	( ) request from individual for Clinic Records (applicable fees apply)	( ) request from Hospital/Clinic Provider (fees do NOT apply)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Last Name:	First Name:	Middle Name:
Other Names Used:	Date of Birth:	SS#:

Address:

Home Phone:	Cell Phone:

*I hereby request access to the protected health information in my health record from (date)*_____ to (date) _____ maintained or created in my hospital or clinic medical record.

( )	progress notes	( )	immunization records
( )	pathology/lab notes	( )	entire record
( )	x-ray/CT/MRI/ultrasound reports	( )	other
( )	billing records		
( )	I will pick up copies of my records	( )	Mail copies to the individual noted below

RECORDS FROM:	**RECORDS TO:**
Name (Clinic/Hospital/Etc.)	Toledo Bend Family Medicine
Address:	Address: 2421 Worth Street Hemphill, Texas 75948
Phone:	Phone: (409) 787-1416
Fax:	Fax: (409) 787-1419

Purpose of request: Circle One of the options

Patient Request Continued Care Referral Insurance Legal Other: Specify

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or discoled in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of the signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, **Sabine Family Medical Center/Toledo Bend Family Medicine** may not condition the provision of treatment or payment for the care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICBLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS).
- The information authorized for release may include protected health information related to mental health.
- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health

Relationship to patient	Date & Signature of Hospital Administrator/CEO (if released for legal purposes)	
Date & Signature of patient/parent or legally authorized representative (**photo ID** must be presented if request is made in person; signature must be **notarized** if request is mailed)	Date & Signature of employee **releasing record** (Hospital Medical Records Director or Clinic Business Office Manager)	Date & Signature of employee **collecting fee** for copies of record (Hospital Medical Records Director or Clinic Business Office Manager) EXCEPTION - fees are not collected for records forwarded directly to a Hospital or Clinic.