Four Oaks Medical Clinic

109 Shult Drive, Columbus, Tx 78934
Phone: 979-732-5794 Fax: 979-732-5795

Authorization for: ❑ Release ❑ Inspection ❑ Amendment
Of Protected Health Information

Patient Name	Date of Birth	SS#
Address		Telephone #

I hereby authorize: ______________________________

____
Name/ Address of person/ organization to which disclosure is to be made

To release information from the medical / mental health records of: ______________________________
Patient Name

To: ______________________________
Name/Address of person/organization to which disclosure is to be made

Fax #: ____________________ Phone #: ____________________

For treatment dates ______________________________
*Specify Dates – this line **MUST BE** completed*

For the following purpose: X Medical Care ❑ Legal ❑ Insurance ❑ Other (detail below)

Select Portions*

❑ Abstract/Pertinent Information	❑ Lab	❑ Progress Notes	❑ Emergency Department
❑ Imaging/Radiology	❑ Orders	❑ History and Physical	❑ Cardiac Studies
X Entire Record	❑ Consultation	❑ Face Sheet	❑ Nursing Notes
❑ Operative/Procedure Report	Mental Health	❑ Shot Records	❑ Other____________

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, psychiatric diagnosis or sexually transmitted disease, you are hereby authorizing disclosure of this information*

This authorization expires 180 days from the date signed below and covers only treatment dates specified above.

I, the undersigned, have read the above and authorize the staff of the above-mentioned facility to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, assigns and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health information.

____________ ______________________________
Date *Signature of Patient/Parent/Guardian/DPA Healthcare*

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Witness

I have the legal capacity to authorize this release
As I am the:

X Patient
❑ Biological Parent with Custody
❑ Legal Guardian (Requires Legal Document)
❑ DPA for Healthcare (Requires Legal Documentation)