

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This information may be disclosed to and used by the following individual or organization. Address: For the purpose of: Progress Notes	I hereby authorize the use or d	isclosure of information from the m	edical record of:	
Address: This Information may be disclosed to and used by the following individual or organization. Address: This Information may be disclosed to and used by the following individual or organization. Address: For the purpose of: Address: Address: For the purpose of: Address: Address: For the purpose of: Address:	Patient Name:		Medical Record #	# :
Address: For the purpose of: Piease release the following:	Date of Birth:	Social Security #	# :	(optional)
Address: For the purpose of: Piease release the following:	I authorize the following indivi	dual or organization to disclose the	above named individual's health	information:
Progress release the following:		Address:		
Please rolesse the following:	This information may be disclo	osed to and used by the following ir	ndividual or organization.	
Please release the following: Proplem List		Address:		
Progress Notes X-ray/Imaging Reports - from (date) to (date)	For the purpose of:			
Progress Notes X-ray/Imaging Reports - from (date) to (date)				
Medication List EKG Reports Immunization Record Other Diagnosis Reports (Specify) Other Diagnosis Reports (Park Other Diagnosis	☐ Problem List☐ Progress Notes☐	☐ X-ray films		
Linderstand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. Yes, I consent to the release of this information. No, I do not consent to the release of this information. Understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. Understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company where 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 in six months. Lunderstand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosure, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact CMG Storeroom at 806-763-3021. Signature	☐ History/Physical Exam ☐ Medication List	□ EKG Reports	e) to (dat	te)
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	Signature of Patient or Legal Repre	esentative	Date	
Date request completed: # of pages copied Reviewed only	Relationship to Patient (If Legal Re	presentative)	Witness	
" of pages completed " of pages copied Total and of the pages copied	Date request completed:	# of pages copied	Reviewed only	

Check #:____

Charges:\$___

Initials:____