AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Parmer Medical Center
1307 Cleveland Avenue
Friona, TX 79035
Phone Number (806) 250-2754
Fax Number (806) 250-2486

I hereby authorize the use of disclosure of my individually identifiable health information. I understand that this authorization is voluntary. 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.

Print Name:_____ **Date of Birth:**_____

Address:_____

RECORDS RELEASED FROM:
PARMER MEDICAL CENTER
1307 Cleveland Avenue
Friona, TX 79035
Phone Number (806) 250-2754
Fax Number (806) 250-2486

RECORDS RELEASED TO:

_____
Name

_____
Address

_____ _____
Phone Number **Fax Number**

Purpose of information to be disclosed:_____

CHECK THE TYPE OF INFORMATION AUTHORIZED TO BE DISCLOSED:
Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider as Provider cannot be responsible for the completeness or accuracy of such records.

☐ **Entire Record**	☐ **Records not prepared by or on behalf of Provider**	☐ **Patient Demographic Information**
☐ **Progress Notes**	☐ **History/Physical Exam**	☐ **Medication List**
☐ **Immunization Record**	☐ **X-Ray/Imaging Reports**	☐ **Lab Test Results**
☐ **EKG Reports**	☐ **Other** _____	☐ **Consultation Reports**

FOR TREATMENT DATES:_____ **Encounter Number*:**_____
(*To Be Filled In By Hospital Employee)

I understand 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 release of this information. **_____NO, I do not consent to the release of this information.**

I understand that the information released is for the specific purpose stated above. Any other use of this information is prohibited. I understand that I have the right to revoke this authorization at any time. 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 the information. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____

I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that my medical record may contain reports, test results, and other notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding entries made in the record to prevent my misunderstanding of the information contained in the record. I will not hold the provider liable for any misinterpretation of the information in my medical record as a result of not consulting that provider for correct interpretation.

I, the undersigned have read the above and authorize the disclosure of such health information described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that fees may be charged for preparing and sending copies as permitted by law. I understand payment must be received before copies will be provided. A faxed or photocopy of this authorization shall be considered valid. I give my permission for this information to be faxed. All blanks and boxes associated with information to be disclosed were filled in before I signed this form.

Signed:_____**Relationship:**_____**Date:**_____

Witness:_____ **Date:**_____

Revised May 2011