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# Dr. Cindy Hutson 2701 S. Georgia

Amarillo, TX 79109

**Authorization to Disclose Medical Information**

## Patient Name: Address:

Date of Birth: Telephone: Social Security Number:

Information to be ***Released FROM***: Information to be ***Released TO***:

Doctor/Clinic:  ***Dr. Cindy Hutson / Dr. Dhana Cox*** Name:

Address: ***2701 S. Georgia*** Address:

***Amarillo, TX 79109***

Phone Number: ***(806) 351-2000*** Phone Number: Fax Number: ***(806) 352-3922 Med Rec Only*** Fax Number: Date Requested: (Check all that apply):

## Discharge Summary History and Physical Pathology Reports EKG Reports

ER Records Consultations Operative Reports X-ray Reports

Immunizations Laboratory Reports Anesthesia

Other:

**Date of service requested: From To**

## I am requesting this information be released for the following purpose:

Continued Care Elsewhere

Insurance

Legal

Personal Use Continuity of Care Other

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 of alcohol and drug abuse. This type of sensitive information will only be released if specifically requested by checking “other” above and stating **exactly** what information is to be released.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when 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 180 days.

I understand 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 assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand 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 **Panhandle Primary Care’s Administrative Supervisor** by calling 351-2000.

### Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Authority to Sign Signature of Witness

(Parent, Guardian, Medical POA, etc.)

Form PPC 2019