AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Address _____

Phone Number (_____) _____ Fax Number (_____) _____

Date of Birth _____ Social Security # _____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

H. B. Hamilton MD, P.A. 205 Woodhew, Ste 200 Waco, TX 76712

Phone (254)776-9775 Fax (254)776-9751

This information may be disclosed TO and used by the following individual or organization:

_____ Address: _____

Phone Number (_____) _____ Fax Number (_____) _____

For the purpose of: _____

Please release the following:

___**History & Physical Exam**	___X-Ray/Imaging Reports-from (date) _____ to (date) _____
___**Chart Notes**	___Other Diagnostic Reports (Specify) _____
___**Operative Report**	___Laboratory Results-from (date) _____to (date) _____
___Rad Reports	___Entire Record
___List of Meds/Allergies	___Other (Specify) _____

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 the 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 without the written consent of the patient is prohibited.

I understand that I have a 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 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 my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.

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 ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, 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 Julie Litke, Privacy Officer for H Bruce Hamilton, MD PA at 254-776-9775.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness