north texas area community health centers

MRN: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Patient SS#: _____

Tel: _____ Address: _____ City: _____ State: _____ **ZIP:** _____

I request to have the information released TO / FROM :

☐ Arlington Community Health Center 979 N. Cooper St., Arlington, TX 76011

☐ Northside Community Health Center 2332 Beverly Hills Dr., Fort Worth, TX 76114

☐ Southeast Community Health Center 2909 Mitchell Blvd., Fort Worth, TX 76105

Tel: 817-625-4254 **Fax: 817-740-8612**

I request to have information released TO/ FROM: ☐ **Request electronic copy only**

_____ _____

Name of Facility/Doctor Phone Number

_____ _____

Address City Zip Fax Number

My authorization extends to those data elements/ document s below:

☐ History & Physical Examination ☐ Progress Notes/Office Visits

☐ Lab/X-ray/Pathology Results ☐ All Records ☐ Other: _____

Purpose of Disclosure: ☐ Continued Medical Care ☐ Insurance ☐ Attorney ☐ Other _____

Texas Health & Safety Code Ann.241.152 (Vernon 2001) requires an authorization for release of medical records to include the reason or purpose of release.

Dates to release records FROM: _____ **TO** _____

Fees for Copying records: 1-20 pages is $25; each additional page will be $0.50. One-time courtesy copy to a physician for continued medical care is at no charge; all copies after that are charged at 1-20 pages is $25; each additional page will be $0.50.
The fee may be waived for records to be used for supporting an application for disability or other under either Aid to Families with Dependent Children; Medicaid; Medicare; Supplemental Security Income, or federal Old- Age and Survivor's Insurance. I have attached a statement which conforms that an application or appeal has been filed or is pending. Fee for producing an electronic copy of the records at the request of the patient is $6.50 per request.

I understand the potential for information disclosed with my authorization to be released by me or the recipient of the information. The North Texas Area Community Health Center may not condition treatment on whether or not you sign this authorization. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance on it. This authorization expires within 90 days from the date of signature below.

Signed : _____ **Date :** _____

Witness: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

☐ Parent/ Guardian of Minor Patient ☐ Beneficiary or personal representative (of deceased patient)

☐ Other _____

FOR OFFICE USE ONLY:

Date Received: _____ Initials _____ Processed: Copied/Faxed/Mailed/Emailed _____ Initials _____