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Authorization to Use/Release/Disclose Health Information

I,_____, understand that Border Clinic PLLC is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to disclosure by the recipient and no longer protected by the Privacy regulations.

Patient's Name:_____ **Date of Birth:**_____

Physician Office / Hospital / urgent Care **Phone Number and Fax**

_____ _____
_____ _____

I authorize the following information to be sent to the above address: (Check all that apply)

- o Copies of Medical Records for the Period:
- o Copies of information described below for the Period:
- o History & Physical Examination
- o Reports from other physicians
- o Lab, X-Ray, etc. reports
- o Other (Please Specify): _____
- o The following information should **NOT** be released (Please specify):_____

Reason for transfer/disclosure: _____

Section B: (Must be completed for ALL Authorizations) I understand that:

- I may revoke this authorization at any time by notifying the Practice in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- Border Clinic PLLC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature:_____**Date:**_____

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUEST