Authorization Form for Release of Protected Health Information

River Park Medical Clinic

By signing this form, I authorize you to use and disclose the protected health information described below.

1. **Patient Name (please print): _____ Date of Birth: _____**
2. **The health information you may release subject to this authorization is as follows:**

___MEDICAL RECORD FOR THE FOLLOWING DATE RANGE: _____

___OTHER AS DESCRIBED: _____
_____

3. **Release my protected health information to the following person(s) / entity:**

____PATIENT (self)

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

____ORGANIZATION / INSURANCE / LAWYER, etc.

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone No: _____ Fax: _____

A FEE of **$25.00** is due for the cost of copying, postage and time spent preparing the records.
Records will be released within 15 business days after
1 - Receipt of this request **AND**
2 - Receipt of fees for furnishing

OFFICE USE ONLY

Date of receipt of request: _____

Date of receipt of payment: _____

4. This authorization shall be in force and effective until the following event and/or date:
_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

~Quang Le, DO ~2550 River Park Drive, Suite 110 ~817-731-1289(phone)
~ Fort Worth TX, 76116 ~817-731-1291(fax)

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

5. I would like my records sent (please check one):

____by mail to the address listed above
____by fax to fax #_____
____in person and I can be contacted at _____when the records are ready
(Phone #)

6. _____ _____
Signature of Patient or Personal Representative Date

7. _____ _____
Printed Name of Patient or Personal Representative Description of Representative's Authority
****(A copy of a Drivers License or ID needs to be provided if not the patient)**