Huntsville Pediatric & Adult Medicine
ASSOCIATES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

I authorize the use or disclosure of the above named individual's protected health information as described below:

☐ **To:** ☐ **From:** **Huntsville Pediatric and Adult Medicine Associates.**
100 Medical Center Parkway Ste. 1000, Huntsville TX 77340
Phone 936-295-8000 **Fax 936-439-1169**

☐ **To:** ☐ **From:**

☐ **Self:** ☐ **Parent Name:** _____ **Phone:** _____

☐ **Physician or Facility Name:** _____

Phone number: _____

Delivery: ☐ **Pick-up**

☐ **Mail**
Address: _____

City, State and Zip Code: _____

☐ **Fax – Fax Number:** _____

The type of information to be used or disclosed is as follows:

☐ Entire Record (see fee below)
☐ Immunizations record ($ 5.00 fee)
☐ Growth Charts ($ 5.00 fee)
☐ Consultation reports – From (Doctor's name) _____
☐ Other (please specify) _____
☐ Physician's progress notes (see fee below)
☐ Laboratory results ($5.00 fee)
☐ X-ray and imaging reports

Reason for Request of Medical Records _____

- **I understand that under the guidelines of the Texas Medical Association, copy fees of $25 for up to 20 pages and $.25 per page thereafter will be assessed. Payment of $25 must be made before copies are made. The remaining balance must be paid before the records are released.**
- **Please allow up to 10 business days for processing.**

By signing this Authorization Form, I understand that I am giving my authorization for HPAM to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. I understand that I may revoke this authorization at any time by notifying HPAM in writing of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by HPAM before HPAM received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for receiving treatment from HPAM. This authorization of release expires 12 months from the date of signature.

Signature of patient or Legal Representative _____ **Date** _____
If signed by Legal Representative, Relationship to Patient _____