Henrikson Primary Care
Lynn Henrikson DNP, ACNP, FNP
3371 Knickerbocker Rd, #236
San Angelo, Tx 76904
Fax 325-703-6672
325-703-6670

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(Please Print)

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

Address: _____

_____

Daytime Phone Number: _____

I hereby authorize my physician(s) and/or administrative and clinical staff at _____

_____

to disclose the protected health information described below to:

Name Lynn Henrikson DNP, ACNP, FNP

Address or Fax Number 3371 Knickerbocker Rd #236, San Angelo, TX 76904 Fax-325-703-6672

Mail: _____ Pickup: _____

Paper: ___ CD: ___ Fax:___

For your convenience we now generate all requested records in paper format unless requested otherwise.

(A separate form is required for visits with psychiatrists.)

Information to be released:
(**NOTE: A fee may be charged for providing your records.**)

____ Medical records for the past year* _____ Medical records for past 2 years*
____ All medical records stored on site for the past _____years.*
____ CT images and report of/on_____.
____ MRI images and report of/on _____.
____ SONO images and report of/on _____.
____ X-RAY images and report of/on _____.
____ Archived records stored off site*
____ Immunization records
____ Lab work of/on_____.
____ ONLY the information described as follows: _____
_____

This protected health information is to be disclosed for the following purpose:_____

IF RECORDS ARE BEING SENT TO ANOTHER DOCTOR OR PROVIDER PLEASE INDICATE REASON: ____Changing Doctor or Provider
____2nd Opinion ___Moving _____ Other _____

***I understand that my records may contain reference to or results of HIV (AIDS) antibody testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history, or substance abuse, and I authorize the release of such confidential information to the indicated party, unless specifically prohibited in my instructions above.**

I understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact of the practice I authorized above to disclose the specified protected health information. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization or during an insurance claim contestability period if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that a photocopy of this authorization shall have the same force and effect as the original authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

EXPIRATION DATE: This authorization is valid until _____, at which time this authorization to disclose this protected health information will expire. If no expiration date is indicated above, I understand that this authorization will be valid for 1 year (360 days) from the date signed.

Signature of Patient/ Legal Representative:_____ **Date**: _____

Relationship to Patient:_____

Witness: _____ **Time**: _____ **Date:** _____