Henrikson Primary Care

3371 Knickerbocker Rd, #236
San Angelo, TX 76904

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

Patient Name_____**DOB**_____

Address_____

Daytime Phone Number_____
I hereby authorize my health care provider and/or administrative and clinical staff at Henrikson Primary Care to disclose the protected health information described below to:

Name_____**Relationship**_____

Information to be released:_____*Any information regarding treatment at Henrikson Primary Care
_____*Results from testing ordered by Henrikson Primary Care
_____CT images and/or reports for_____
_____MRI images and/or reports for_____
_____Ultrasound images and/or reports for_____
_____X-ray Images and/or reports for_____
_____ONLY the information described as follows_____

This protected health information is to be disclosed for the following purpose:
_____ Family member participation in health care.
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 Henrikson Primary Care. 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 any authorization was obtained as a condition or obtaining insurance coverage.
I understand that a photocopy of the 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 to 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 1year (360 days) from the date signed.

Signature of patient/Legal Representative Date

_____
Relationship to patient

_____
Witness Date