AUTHORIZATION TO RELEASE HEALTH INFORMATION

PLEASE COMPLETE ENTIRE FORM

Name of Provider/Facility: I hereby authorize _____ to release health records information on:
Address _____ City _____ State ____ Zip _____
Office Phone # _____ Fax # _____

Patient Name:_____ Date Of Birth:_____ Social Security #_____
Patient Phone Number 1._____ 2._____
Primary Secondary

For Healthcare Covering the Periods from _____To:_____ **OR** _____ all dates
For the purpose(s) of: _____

PLEASE RELEASE RECORDS TO:

Name of Provider/Facility **Village Family Practice**
Address: 9055 Katy Freeway, Suite 200
Houston, TX 77024 ph: 713- 461-2915 fax- 713-461-5307

I ☐ do ☐ do not (check applicable box) authorize this information to be faxed. If yes:
Fax Number: _____ Name of Person to Receive Fax_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
☐ **Yes,** I consent to the release of this information. ☐ **No**, I do not consent to the release of this information.

REVOCATION: I understand that this authorization maybe revoked in writing at any time, except the extent that actions have already been taken in response to this authorization for the purposes stated above.

Unless otherwise indicated, this authorization will expire in ninety (90) days from date of signature. The physician and employees are released from any legal responsibility or liability for disclosure to the above information to the extent indicated and authorized herein.

Medical care is not conditional upon the signing of this authorization**.**
WARNING: Your Personal Health Information (PHI) may be re-disclosed by the receiving entity.

I understand that there may be a fee for preparing and furnishing this information

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as result of not consulting my physician for the correct interpretation.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

Preparation Fee $25.00 for the first 20 pages $0.50 per additional page **Copy OF Billing Records $25.00**

TO BE COMPLETED BY VILLAGE FAMILY PRATICE STAFF ONLY!

Date request completed _____ # pages copied _____ Charges $ _____

Send out by _____ *Method* _____Mailed _____Faxed _____ Picked up_____