

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION TO
FAMILY MEMBER(S)
(Please Print)**



Patient Name _____ Date of Birth _____

Address _____

Daytime Phone Number _____

I hereby authorize my physician(s) and/or administrative and clinical staff at West Texas Medical Associates to disclose the protected health information described below to:

Name _____

Relationship _____

**Information
to be released:**

- _____ *Any information regarding treatment with Dr. _____
- _____ *Results from any laboratory and/or radiological testing ordered by Dr. _____
- _____ CT images and Report for _____.
- _____ MRI images and Report for _____.
- _____ Sono images and report for _____.
- _____ X-Ray images and report 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.

***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 Officer at West Texas Medical Associates. 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 ninety (90) days from the date signed.

Signature of Patient/ Legal Representative

Date

Relationship to Patient

Witness

Date