# Rice Medical Associates Patient Authorization for Disclosure of Health Information

Patient Name:_______________________________________________ Date of Birth:__________________
Address:________________________________ City:_________________ State:_____ Zip:_____________
E-mail Address:___________________________________ Phone Number:___________________________

**I request that my protected health information (PHI) be released from:**
Senders Name:__________________________________________________________________________
Address:________________________________ City:_________________ State:_____ Zip:_____________
E-mail Address:___________________________________ Phone Number:___________________________
Fax (healthcare provider only):__________________________________________________________
**I request that my protected health information (PHI) be released to:**
Recipient Name:_________________________________________________________________________
Address:________________________________ City:_________________ State:_____ Zip:_____________
E-mail Address:___________________________________ Phone Number:___________________________
Fax (healthcare provider only):__________________________________________________________

**I authorize the following PHI to be released from my medical record:** □ Laboratory Reports □ Radiology Reports □ Immunization Records □ Complete Medical Record (all pages) □ Itemized Billing Records
□ Test Result(s) of:_______________________________________________________________________
□ Other:_________________________________________________________________________________
**Covering the period of healthcare from:** Specific Date(s):__________________ to __________________ **OR**
□ All past, present, and future encounters/visits
**Purpose for requesting information:** □ Legal □ Insurance □ Personal □ Continuation of Care
**Disclosure Format (Paper is default if not marked):** □ US Mail □Fax □ Other:_________________________

**I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment for alcohol and/or drug abuse.** ***State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained*** (include dates where appropriate):

| | | | |
|---|---|---|---|
| Alcohol, Drug, or Substance Abuse Records | □ Yes | □ No | Dates:______________________________ |
| HIV Testing and Results | □ Yes | □ No | Dates:______________________________ |
| Mental Health Records | □ Yes | □ No | Dates:______________________________ |
| Psychotherapy Records | □ Yes | □ No | Dates:______________________________ |
| Genetic Records | □ Yes | □ No | Dates:______________________________ |

**By signing this authorization form, I understand that:**

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Dept at the following address: 610 S Austin Road, Eagle Lake, TX 77434. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:__________________________. If I fail to specify an expiration date/event/condition, this authorization with expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____________________________________________ _____________________________________________
Patient or Authorized Representative Signature Date

_____________________________________________ _____________________________________________
Print Name Relationship to Patient (if applicable)