HILLCROFT MEDICAL CLINIC ASSOCIATION
AUTHORIZATION TO RELEASE MEDICAL RECORDS
FAX: 713-917-5785

I, _____, residing at _____ in the city of _____ in the state of _____ hereby authorize:

Name: HILLCROFT MEDICAL CLINIC ASSN.

Address: 2500 FONDREN RD.

City, St., Zip: HOUSTON, TX 77063

to disclose the following specific medical information by mail to:

Name: _____

Address: _____

City, St., Zip: _____

from the health records of:

Name: _____

Address: _____

City, St., Zip: _____

for the purpose of: _____.

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments
_____ Records of visits (All visits)
_____ Record of visit for a specific date or dates. Specific dates include or are limited to: _____
_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
_____ Progress Notes
_____ Photographs, videotapes, digital or other images
_____ Discharge Summary
_____ History and Physical Examination
_____ Consultation Reports
_____ **All of the above**
_____ Other (Must be specific) _____
_____ Mental Health and/or alcohol and drug abuse treatment
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
_____ Hepatitis information

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This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Hillcroft Medical Clinic Association, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Patient's name printed **Patient DATE OF BIRTH**

_____

Patient's Signature (or Guardian, if a Minor)

Date Signed _____ Expiration Date_____ (If other than one year from date above)

_____ _____

Patient's Personal Representative Date

_____ _____

Patient's Personal Representative Authority to Act Witness

***Texas Statute fee for copying medical records: $25.00 for the first 20 pages, $.50 each page thereafter, plus postage.**