Frontera Healthcare Network

Office Use ONLY
Date :_________ Received:______________
Release Method:________________________
Charge:_______________________________

Authorization for the Release of Information

I hereby grant my permission for the release or review of the following information concerning my health care.

Physician/Site Authorized to **Release** Information:
Name:____
Address:______________________________________
____
Phone:________________Fax:___________________

Physician/Site/Person Authorized to **Receive** Information:
Name:____
Address:_______________________________________
____
Phone:__________________Fax:__________________

For the purpose of: __ Self/Transfer of Care __ Continuity of Care/Treatment
__ Insurance/Disability Claim __ Attorney/Legal __ Other: ___________________

*Required

*Patient Name (include previous name):____

*Date of Birth:_________________________ Last 4 digits of Social Security Number:______________________

*Phone:_________________________ Address:____

Apt #:_______________ City/State/Zip:____

Information to be Released:

__ Complete Health Record
__ Chart Notes
__ Laboratory Reports
__ Pathology Reports
__ Radiology Reports
__ Other (specify) ________
__ Consultations
__ Operative Reports
__ History & Physical
__ ER Reports
__ Immunizations
__ Dental Records

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Dates of Treatment:________________________________

I understand this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing below, I am specifically authorizing the release of this information:

___ Drug/Alcohol Abuse Treatment
___ Mental Health Records
___ Psychotherapy Notes
___ Genetic Testing

____
Signature of Patient/Guardian Date

This consent expires 180 days from the date of signature unless I specify an earlier expiration date in the provided space: _________________. After the effective date, I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to Frontera's Privacy Contact at: Attn: Health Records, Privacy Contact at 604 Eaker St., Eden, TX 76837. If I later revoke this consent, the revocation Is not effective for uses or disclosures that Frontera has made in reliance on my consent or if my consent was obtained as a condition of obtaining Insurance coverage and the insurer has a legal right to contest a claim. Information used or disclosed pursuant to this Consent may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that Frontera will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide consent for the requested use or disclosure of protected health Information.

____________ ____ ______________________________________
(Date) (Patient/Guardian/Representative Signature) (Witness)

__ HCPOA __ Executor __ Guardianship forms received

If the above signature is not the patients, explanation will be provided along with any necessary documentation.

___ Minor ____ Deceased ____ Other (specify)___________________________________