kind CLINIC
A PROGRAM OF TEXAS HEALTH ACTION

MEDICAL RECORDS RELEASE FORM
Fax to: 833-938-5463

By signing this form, I authorize the **KIND CLINIC** to release/obtain confidential health information about me, by releasing/receiving a copy of my medical records, a summary, or narrative of my protected health information, to the physician/person/facility/entity listed below.

Client Name (Print) **Patient Date of Birth**

Please release the following information, indicated by an "X":

□ Complete Medical History	□ History and Physical	□ Pathology Reports	□ Social Work/Manager Notes
□ Lab Reports	□ Hospital Records	□ Medication Records	□ Special Needs/ Concerns
□ Operative Reports	□ Progress Notes	□ Treatment Records	□ Other: _____
□ Allergies Records	□ Nursing Notes	□ Care Plan	_____

□ I authorize the **KIND CLINIC** to **RELEASE** my protected health information to the following physician/person/facility/entity below:

□ I authorize the **KIND CLINIC** to **OBTAIN** my protected health information from the following physician/person/facility/entity below:

□ **Self/Legal Guardian** *(only for release purposes)* □ **Physician/Person/Facility/Entity** ***(Please Fill Information Below)***

Name/Physician/Facility/Entity

Phone Number **Fax Number**

Address

City **State** **Zip Code**

Please release my medical information via: □ **Mail** □ **Fax** □ **Pick-up** □ **Verbal/Phone**

The client or the client's representative must read the following statements:

I, the undersigned client or legal guardian, understand that I may revoke this authorization at any time in writing or orally, except for information already released and that in any event this authorization shall expire in six months from when it is signed unless otherwise specified (Otherwise specified date _____). I understand that the revocation of this release may result in no longer being eligible for services from Kind Clinic. Upon expiration, Kind Clinic can no longer use or disclose my information for the above purposes without a new authorization. *I understand that the above information may include records/reports from other health care providers involved in my care and treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.* ***I understand that the above requested information may include results of sexually transmitted disease and AIDS/HIV tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/substance abuse and/or diagnosis and treatment of psychological disorders.*** *I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will get a copy of this form if requested.*

Client Name (Print) **Client Signature** **Date**

Parent/Legal Guardian Name (Print) **Parent/Legal Guardian Signature** **Date**

FOR OFFICE USE ONLY:

Medical Information Released Via	Date/Time Completed	Initials

TO THE PARTY RECEIVING THIS INFORMATION: *This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, and Texas Health and Safety Code §85.115 prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.*