True Results Austin
12007 Technology Blvd, Ste210
Austin, TX 78727

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I, _____ hereby voluntarily authorize the disclosure of information from my health record.
Name of Patient

II. **The Information is to be disclosed by:** _____ **And is to be provided to:** _____
Name of Facility — Name of Person /Organization/Facility

Care Physician, PA

Address — Address

City / State — City / State

Austin, TX

III. The purpose or need for this disclosure is:

☐ **Further Medical Care** ☐ **Attorney** ☐ **School** ☐ **Research**
☐ **Personal Use** ☐ **Insurance** ☐ **Disability** ☐ **Other *(Specify)*** _____

IV. The Information to be disclosed from my health record: ***(check appropriate box(es)***

☐ Only information related to (*specify)* _____

☐ Only the period of events from _____ to _____

☐ Other (*specify)(CHS,Billing, etc.)* _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (*Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Custodian of Medical Records, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining Insurance coverage or a policy of Insurance, other law may provide the Insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(specify new date)

I understand that Care Physicians, PA will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.
I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45-CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a]

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (*State relationship to* *patient*) **Date**

SIGNATURE OF WITNESS (*If signature of patient is a thumbprint or mark):* **Date**

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5USC 552a (i)(3))

PATIENT IDENTIFICATION	NAME(*Last, First, Mi)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH