Family Care Clinics
*Your Affordable Healthcare Solution*
www.FamilyCareClinics.net

| ☐**Carrollton** | ☐**North Dallas** | ☐ **NRH** | ☐**Plano** |
|---|---|---|---|
| 3044 Old Denton Road | 11722 Marsh Lane | 8415 Davis Blvd | 909 W. Spring Creek Pkwy |
| Suite 317 | Suite 372 | Suite 307 | Suite 480 |
| Carrollton, TX 75007 | Dallas, TX 75229 | North Richland Hills, TX 76182 | Plano, TX 75023 |
| (P) 972-242-4440 | (P) 214-366-0061 | (P) 817-893-9200 | (P) 972-517-0600 |
| (F) 972-242-4949 | (F) 214-366-0062 | (F) 817-893-9300 | (F) 972-517-1166 |

# Authorization for Release of Information

1. Release information from the clinic of record for:

_____ _____/_____/_____ _____
Patient's Name (Please Print) Date of Birth (MMDDYYYY) Social Security Number

_____ _____ _____
Date of Treatment (MMDDYYYY to MMDDYYYY) Phone Number Work Phone Number

2. I hereby authorize Family Care Clinics to release information and/or obtain information from:

_____ _____
Doctor, Hospital, Insurance Company, Attorney, etc. to receive/obtain information Fax Number

_____ _____
Address Phone Number

For the purpose of: _____

3. Information to be released:

☐ Entire Chart
☐ History and Physical
☐ Physician Discharge Summary
☐ Progress Notes
☐ Laboratory Notes
☐ Other (Specify): _____
☐ Radiology Reports
☐ EKG
☐ Consultation Reports
☐ Physical Examination
☐ Master Treatment Plan

4. I understand that the specific information to be disclosed my include history of Drug or Alcohol Abuse or Mental Health Treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Immune Deficiency Syndrome (AIDS), laboratory test results, treatment progress, and any other such related information.

5. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire 180 days from the date of my signature or condition as follows:

_____

6. I further authorize that a photocopy of this authorization is acceptable as an original.

X_____ _____
Signature of Patient or Legal Representative Date

_____ X_____
Relationship to Patient Witness Signature