☐ Brushy Creek Family Physicians
7200 Wyoming Springs Drive#1500
Round Rock, TX. 78681
Phone# 512-218-8696
FAX# 512-218-9532

☐ Brushy Creek Family Physicians
4112 Links Lane #201
Round Rock, TX. 78665
Phone#512-672-8933
FAX# 512-672-8937

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (_____) _____ Cell Phone # (_____)_____

I hereby request and authorize my medical records:

Released to: (Name &/or Facility)

_____

_____

_____

Released from: (Name &/or Facility)

_____

_____

_____

This authorization applies to all of the reports checked below:

☐	Complete Medical Record	☐	Progress Notes	☐	E.R. Information
☐	Electrocardiogram (EKG)	☐	Exercise Stress Test	☐	Medication List
☐	Labs	☐	Consult Notes	☐	Itemized Ledger
☐	Immunizations	☐	X-Ray		Other:_____

Purpose of disclosure: (check all that apply)

☐ Continuation of Medical Care ☐ Transferring In/Out ☐ Insurance ☐ Attorney
☐ Other _____

Authorization to Release Protected Information:

***Required** – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records?	Initial to confirm your choices
I ☐ DO ☐ DO NOT want ***Psychiatric Treatment Notes** released	_____
I ☐ DO ☐ DO NOT want information about ***Mental Health** released	_____
I ☐ DO ☐ DO NOT want information about ***HIV Tests & Related Information** released	_____
I ☐ DO ☐ DO NOT want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ DO ☐ DO NOT want information about _____ released	_____

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee.

This authorization is valid for one year unless otherwise stated.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient's Printed Name

_____ _____
Signature of Witness Date