Goodall-Witcher Clinic in Clifton
201 Posey Avenue
Clifton, TX 76634
254-675-8621
254-675-3279 (HIM Fax)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Date of Birth:_____ SS#:_____

I authorize the following individual or organization to disclose the above named individual's health information:

Goodall-Witcher Clinic in Clifton Address/Phone: 201 Posey Ave., Clifton, TX 76634

This information may be disclosed **TO** and used by the following individual or organization:

_____ Address/Phone: _____

For the purpose of: _____

Please release the following:

___ Progress Notes	**___ History/Physical Exam**	**___ Medication List**
___ Immunization Record	**___ List of Allergies**	**___ X-Ray/Imaging Reports**
___ Laboratory Results	**___ EKG Report**	**___ Other Diagnostic Reports**

___ Other Records (Specify) _____

This authorization covers the patient care given from _____ to _____
Date **Date**

I understand that the information released is for the specific purpose stated above. Any other use of the information without the written consent of the patient is prohibited. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.
I understand that disclosing my information is voluntary, that it may contain reports, test results, and notes that only a physician can interpret. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at Goodall-Witcher Clinic in Clifton.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Relationship to Patient (If Legal Representative) **Witness**