Arlington Family Health Pavilion
707 N. Fielder Rd, Suite A
Arlington, TX 76012
Office: 817-277-2671
Fax: 817-460-3004

Authorization for Release/Disclose Protected Health Information

Patient Name: _____D.O.B_____/____/_____
Address: _____
City _____State _____Zip_____
Home: _____Cell:_____
Date Records Requested: ___/___/____

I, authorize Arlington Family Health Pavilion to request or send my medical records from the following doctor:
(Please check one) ☐ **Send to** ☐ **Request from**

Doctor's Name: _____
Address: _____City _____State ____Zip_____
Phone: _____Fax: _____

Information Being Requested: Please describe the information that you would like to be released or obtained. (*Please include inclusive dates and/or specific type of records*)

_____

_____

_____

Instructions: _____

Review Procedures:
Your request to inspect or copy your protected health information will be reviewed by our privacy official, who will determine if the information requested may be available to you. We may be legally prohibited from making certain information available to you or your representative, including:

- Psychotherapy notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or to another person
- Information obtained under a promise of confidentiality

Within the limitations of the law, we will make every effort to accommodate your request. We will:

- Complete our review of your request and either arrange for you to inspect your records within **30 days** of your request
- Provide you with a written explanation of any request that we review that decision if we deny your request, in whole or in part, you may request that we review that decision.

Patient Acknowledgment

- I understand that the records used and disclosed pursuant to this authorization may include information relating to: Genetic counseling, human immunodeficiency virus (HIV) or acquired Immunodeficiency Syndrome (AIDS) treatment, history of drug or alcohol abuse, mental, behavioral health or psychiatric care, and/or other sensitive information.

- I understand that I may revoke this authorization in writing at any time except to the extent that Arlington Family Research Center has relied on this authorization. The written revocation should be addressed to the Records Department, unless otherwise revokes, I understand that the date or event which this authorization expires 180 days from the date of signature. A photo copy of this authorization is considered as valid as the original.

- I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and therefore, may be subject to re-disclosure by the recipient.

- I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 and HIPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.

Patient Signature

_____

Name of Patient (Print) Signature of Patient Date

_____

Signature of Patient Representative Relationship of Representative
(Required if the patient is a minor or an adult who is unable to sign this form)