Medical Arts Rural Health Clinic
2202 North Bryan Avenue
Lamesa, Texas 79331
Phone: (806) 872-7494
Fax: (806) 872-1130

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Medical Record Number: _____ Social Security Number (optional): _____

Patient Number(s): _____

1. **I hereby authorize Medical Arts Rural Health Clinic to use and/or disclose the above named individual's health information as described below.**
2. **The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):**

   Dates of Service: _____

   ☐ Clinic Notes ☐ Lab Report ☐ X-ray report ☐ EKG ☐ Pathology Reports
   ☐ Itemized Bill ☐ Entire Record ☐ Other (Specify): _____
3. **The information identified above may be RELEASED TO / REQUESTED FROM the following individuals or organization(s):**

   Name: _____

   Address: _____

   Phone / Fax: _____
4. **This information for which I am authorizing disclosure will be used for the following purpose:**
   ☐ Personal Use ☐ Disability ☐ Medical Care ☐ Insurance ☐ Legal ☐ Other (describe): _____
5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
6. I understand that I have a 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 Health Information Management department. I understand that the revocation will not apply to information that has already been 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 consent a claim under my policy.
7. This authorization will expire (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which is was signed.
8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Medical Arts Hospital, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
9. I have a right to receive a copy of this authorization.
10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon this authorization.

_____ _____
Signature of Patient or Legal Representative Date / Time

_____
If Signed by Legal Representative, Relationship to Patient

_____ _____
Signature of Witness Date / Time

Identity of Requestor Verified Via: ☐ Photo ID ☐ Other (describe): _____