Chelsea I. Clinton, M.D.

18585 Sigma Rd., Ste 102
San Antonio, TX 78258

Phone: 210-591-0688 Fax: 210-546-1238

Authorization for Release of Patient Information (page 1)

Information regarding patient for whom authorization is made:

Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: ( ) _____ Email (*Optional*): _____

Information regarding health care provider/entity authorized to disclose this information:

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: ( ) _____ Fax: ( ) _____

Information regarding person or entity who can receive and use this information:

Name: C.I. Clinton, Rheumatology, PLLC
Address: 18585 Sigma Rd. Ste. 102, San Antonio, TX, 78258
Phone: (210) 591-0688 Fax: (210) 546-1238

Specific information to be disclosed:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

Include: (*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:

(Choose all that Apply)

☐ Treatment/Continuing Medical Care

☐ Personal Use

☐ Billing or Claims

☐ Insurance

☐ Legal Purposes

☐ Disability Determination

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Authorization for Release of Patient Information (page 2)

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: - _____

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Special Information: This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____

Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____

Date: _____