Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____Date: _____

Previous Name: _____Date of Birth: _____

I request and authorize ____Dr. Jordan Mitchell_____ to release healthcare information of the patient named above to:

Name: _____Fax#_____

Address: _____

City: _____ State:_____ Zip: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All Healthcare information

Reason for release:

☐ Personal Use ☐ Transferring Care ☐ Insurance request ☐ Other

This authorization includes the release of information about the following, if it included in the medical record, AIDS, HIV related information or testing, psychiatric disorders, drug treatment, and/or alcohol treatment. The specific dates of such records to be disclosed include:_____ I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined in HIPAA to ensure accuracy. I understand that I have a right to limit the type of information release and to revoke this authorization by submitting a notice, in writing to you. Unless revoked, this authorization will expire on the following date: _____. If I chose to limit the information released, I understand that you may inform the requestor that portions of the record have been withheld. You are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

I understand that information will be provided within 15 days from receipt of request and a fee for preparing and furnishing this information may be charged to me according to the rulings set forth by the Texas State Board Of Medical Examiners.

_____

Patient Name {Printed} Signature of Parent or Guardian

_____

Printed Name of Guardian Guardian's Relationship to Patient

Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED