Lubbock Urology Clinic, L.L.P.

HIPPA Medical Records Release Authorization Form

Patients Name:_____ Date of Birth ____/____/_____

Previous Name: _____ SSN# _____/_____/_____

I hereby authorize _____to release / disclose medical information for the above named patient by: _____Mail _____Email _____Fax _____ Pick Up to / by the following individual or entity.

Name: _____

Address: _____City, State, Zip Code: _____

Phone: _____

Purpose of Release:

☐ Consultation / Coordination of Care ☐ Transfer of Care ☐ Insurance ☐ Other (please specify) _____

Documents Needed:

☐ All Medical Information	☐ Hospitalization (s)	☐ All Diagnostic test results
☐ Pathology report (s)	☐ Radiology Only	☐ Laboratory Only
☐ Operative report(s)	☐ Hospital consult report(s)	☐ Progress note(s)
☐ Other (please specify)		

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the results of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initiated below or otherwise required by law.

May NOT include information related to (please check and initial)

_____ HIV/AIDS _____Mental Health _____Drug and/or Alcohol Abuse

This authorization is given freely with the understanding that:

1. **A photocopy or fax of this authorization is as valid as the original.**
2. **I may inspect or copy the protected health information to be used or disclosed. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.**
3. **I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit an authorization to do so to Lubbock Urology Clinic, LLP at 6102 82nd Street, Suite 5, Lubbock, Texas 79424. Attn: Medical Records**
4. **Lubbock Urology Clinic and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. This authorization is valid from the date signed below until the expiration date noted below. If no expiration date is noted then the authorization will expire one (1) year from the date of the patient / representative signature.**
5. **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.**
6. **I understand that I need not sign this in order to ensure health care at this facility.**
7. **If I have questions about the disclosure of my health information, I can contact LUCs, privacy officer.**

Patient Printed Name: _____ Date of Birth: _____

Patient / Legal Guardian Signature: _____ Date: _____

Relationship to Patient (If Legal Guardian) _____ Expire Date of Auth: _____

Witness: _____Date: _____