HAMILTON HEALTHCARE SYSTEM

Hamilton General Hospital
400 North Brown Street
Hamilton, TX 76531
Phone (254) 386-1600
Fax (254) 386-3047

Family Practice Rural Health Clinic
400 North Brown Street, Bldg II
Hamilton, TX 76531
Phone (254) 386-1700
Fax (254) 386-4839

Hico Clinic
PO Box 597
Hico, TX 76457
Phone (254) 796-4224
Fax (254) 796-4064

Family Practice of Mills County
1501 West Front Street
Goldthwaite, TX 76844
Phone (325) 648-2850
Fax (325) 648-2853

Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____

Medical Record Number: _____ SS#: _____

1. I hereby authorize Hamilton Healthcare System 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: _____

☐ History / Physical	☐ ER Record	☐ EKG
☐ Discharge Summary	☐ Lab Report	☐ Clinic Notes
☐ Operative Reports	☐ X-Ray Report	☐ Complete Medical Record
☐ Consultation Reports	☐ X-Ray Films	☐ Itemized Bill
☐ Pathology Reports	☐ MARS	☐ Complete Billing Record
☐ Immunizations	☐ Other: (Specify)	_____

3. 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.
4. The information identified above may be released to / requested from the following individuals or organization(s):

Name: _____

Address: _____

Phone/Fax: _____

5. This information for which I'm authorizing disclosure will be used for the following purpose

☐ Medical Care ☐ Insurance ☐ Litigation ☐ Other (describe): _____

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 contest 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 it 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.
9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of patient or legal representative — Date

If signed by legal representative, relationship to patient: _____

_____ _____

Signature of witness — Date

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

☐ Copy of Release Provided To Patient