AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the City of Kerrville, Texas to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that neither my health care nor the payment of my health care will be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the released information may no longer be protected by federal and state privacy regulations. I understand that the specified information to be released may include, but is not limited to: history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable diseases including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that this authorization will expire one (1) year from the date of signature or at the date or event specified here _____(expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, the City of Kerrville, Texas Fire/EMS Department. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another healthcare provider.

Patient Name	Last 4 of SSN	Date of Birth	Date of Service
Street Address City, State, Zip		Telephone Number	

The information will be released to: ☐ Patient/Designee ☐ Healthcare Entity ☐ Insurance Company ☐ Attorney ☐ Other

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other _____
Record copy format: ☐ Paper ☐ CD ☐ _____
Record copy delivery: ☐ Pick-up ☐ Mail ☐ Fax to healthcare off. ☐ Email _____
If emailed choose one: ☐ Encrypted ☐ Unencrypted
The health information will be sent by encrypted email unless I specify otherwise. By requesting unencrypted email, I acknowledge that there is some risk that health information could be accessed by a third party.

INFORMATION TO BE RELEASED:
☐Medication ☐Billing Record ☐ Patient Care Report ☐Other:_____

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Medical Information request. I consider this as my electronic signature for this request.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

_____
Representative's Authority to Act for Patient (attach supporting documentation)