GOODALL-WITCHER
Hospital Authority

Clifton Medical Clinic
201 Posey Ave
Clifton, TX 76634
254-675-8621
254-675-1913 (fax)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ **Date of Birth:** _____

I authorize the following individual or organization to disclose the above named individual's health information:

Clifton Medical Clinic Address/Phone: 201 Posey Ave., Clifton,TX 76634

This information may be disclosed **TO** and used by the following individual or organization:

_____ Address/Phone: _____

For the purpose of: _____

Please release the following:

___ **Progress Notes**	___ **History/Physical Exam**	___ **Medication List**
___ **Immunization Record**	___ **List of Allergies**	___ **X-Ray/Imaging Reports**
___ **Laboratory Results**	___ **EKG Report**	___ **Other Diagnostic Reports**

___ **Other Records (Specify)** _____

This authorization covers the patient care given from _____ to _____

I understand that the information released is for the specific purpose stated above. Any other use of the information without the written consent of the patient is prohibited. I understand I have the 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 individual or organization releasing information. I understand that the revocation will not apply to information already 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. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.
I understand that disclosing my information is voluntary, that it may contain reports, test results, and notes that only a physician can interpret. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at the Clifton Medical Clinic.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness