COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Authorization for Release of Information
200 Sydney Blvd
Thorndale, Texas 76577
Request by Patient or Patient's Representative

I hereby authorize Country Meadows Clinic to release or receive my individual, identifiable health information as described below, including, but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that this information may be subject to redisclosure by the recipient and is no longer protected by HIPAA. I further understand that I will not be denied treatment for refusal to sign this form.

Patient Name: ______________________________

Date of Birth: ____________ **Treatment Dates:** ____________

Address: ______________________________

City: ____________ **State:** ______ **Zip:** ________ **Telephone number:** ____________

<u>This information is to be released:</u>

To: CMC (Country Meadows Clinic)
200 Sydney Blvd
Thorndale, TX 76577
Ph: 512-898-4001 **Fax:** 512-399-5274

From: ______________________________
____
____
Ph: ____________ **Fax:** ____________

<u>Please check the information to be released:</u>

____ Medical Records _____ Billing Records ____All Records

<u>Purpose of disclosure:</u>

____Continued Patient Care ____ Attorney/Legal ____ Personal Use ____ Commercial Insurance

I understand that CMC will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners. It is further understood that the information released is for the specific purpose stated above and will not be provided in whole or in part to any other agency, organization, or person by Country Meadows Clinic. This consent will expire 180 days after the date of signature, or may be revoked in writing at any time.

______________________________ ____________
Signature of Patient or Patient's Representative Date

Relationship to Patient: ______________________________