West Texas Developmental Pediatric & Behavioral Health Network, P.A.

3301 101st Street
Lubbock, Texas 79423
(806) 281-9966

Authorization To Release Protected Health Information

This form **must** be completed in its entirety to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulation. If any field is left blank, the authorization will be considered void.

Patient's Name: ____________________ Date of Birth: ____________ SS#: ____________

Address: ________________________ City, State ______________ Zip: ________

Home Phone #:____________ Work Phone#: ____________ Cell Phone#: ____________

I authorize the following facility:
(releaser of records)

Name: ________________________________

Fax #: ________ Address: ________________________________

City, State: ________________________ Zip: ________

To release the Personal Health Information indicated below:

____ Entire Medical Record ____ Hospital Records ____ Laboratory Reports ____ Pathology Reports

____ Diagnostic Imaging Reports ____ Progress Notes ____ Psychotherapy Notes ____ Billing Records

Other (specify): ________________________________

To the office of:
(receiver of records)

Name: **West Texas Developmental Pediatric & Behavioral Health Network , P.A.**

Fax #: **(806) 281-9964** Address: **3301 101st Street**

City, State: **Lubbock, Texas** Zip: **79423**

I hereby discharge the releasing and receiving facilities, its agents, and employees from all liabilities, responsibilities, damages, and claims, which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit. I understand further use or disclosure of the authorized information by the above named agency/individual may not be accomplished without my further written authorization.

This authorization will automatically **expire 60 days** after the date below, unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time in writing, as stated in the Notice of Privacy Practices, except where the office has already made disclosures in reliance upon my prior authorization.

Patient's Signature: ____________________ Date: ____________ Expiration Date: ________

Relationship To Patient: ____________________ Witness Signature: ____________________

**** There may be a charge for copying Medical Records.**