

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

Fax #: _____ Address: 3301 101st Street

City, State: Lubbock, Texas Zip: 79423

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: _____

Fax #: _____ Address: _____

City, State: _____ Zip: _____

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: _____