Associates of Internal Medicine
AIM for your health
Primary Care Physicians

Authorization for Release of Protected Health Information (Medical Records)

Patient's Name:	Birth Date:	Social Security No. (optional)
Maiden/Former Name:	To Release to: **Associates of Internal Medicine**	
I, Authorize:	At Address: **2260 College Avenue** **Fort Worth, TX 76110**	
	Or Fax: **817-870-3636**	
Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ Attorney ☐ Other: _____	The following information may be released: ☐ Entire Medical Record ☐ Specific Record from _____ to _____ ☐ Immunizations ☐ Billing Record ☐ Only: _____	

The following information may be released:

	I consent to the release of the indicated sensitive, legally protected records (patient to initial). Mental Health Records……_____ HIV or AIDS……_____ Chemical Dependency……_____ Genetic Testing……_____	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.
4. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of patient or Representative:	**Date:**
Print Name of Representative:	**Relationship to Patient:**