AUTHORIZATION FOR RELEASE OF INFORMATION
THIS REQUEST MUST BE FILLED OUT COMPLETELY

Patient's Name: _____ SS#_____DOB:_____

Address: _____

I authorize BSA Amarillo Diagnostic Clinic to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal and state privacy regulations. I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____Your initials are required to release records with drug, alcohol, or substance abuse; mental health; Genetic information; HIV/AIDS test results/treatment.

Information to be released **TO:**

_____
_____
_____
_____

FROM: _____
Name of physician(s)
Amarillo Diagnostic Clinic
6700 W. 9th
Amarillo, TX 79106-1701
806 358-0200 Fax 806 356-5590

Information to be released: (Check applicable) **Dates of Service**: From:_____To:_____

__ History/Physical Exam Notes
__ Laboratory Results
__ X-Ray Reports
___ Other Diagnostic Reports (Please specify)
_____

Reason or Purpose for Release: (Check the appropriate category)

___ Continued Patient Care
___ Insurance Claim/Application
___ Attorney/Legal
___ Personal Use
___ Disability Determination/Social Security
___ Other (Specify) _____

I understand that the information released is for specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Patient's Legal Representative Date
(Please attach supporting documentation for legal representative)

---------- **For office use only** ----------

Records picked up _____ Records sent _____ Date _____ Initials _____

ID checked _____