WOODROME MEDICAL PA
Phone 936-327-9944
MEDICAL RECORDS RELEASE TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB:_____
ADDRESS: _____
CITY: _____STATE: _____ Zip: _____
Phone: _____ Email: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Woodrome Medical PA Location _____
Address: _____City: _____ State: ____ Zip Code: _____
Phone: _____ Fax _____

WHO CAN RECEIVE AND USE THE HEAL TH INFORMATION?

Person/Organization Name _____
Address: _____City: _____ State: ____ Zip Code: _____
Phone: _____ Fax _____

The health information you may release subject to this authorization is as follows:

From service date: _____ to _____

_____ All medical records _____ Lab _____ Radiology _____ Consult Notes

Your initials are required to release the following information:

- HIV/AIDS test results/treatment _____
- Drug, Alcohol, Substance Abuse Records _____
- Genetic information (including genetic test results) _____
- Mental Health Records (excluding counseling notes) _____

EFFECTIVE TIME PERIODL. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this
authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEAL TH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Signature of Individual or Individual's Legally Authorized Representative Date

Email request to: medicalrecords@wd-fm.com