Rocky Creek Family Medicine
Deirdre McMullen M.D. Hillary Spears FNP-BC Jakelyn Alfaro FNP-BC
3281 Rocky Creek Drive, Ste 500 Missouri City, TX 77459
Phone: 281-206-0068 Fax: 281-499-5045

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth**: _____

Previous Name: _____ **Phone #**: _____

I request and authorize:

Name/Facility: _____

Address: _____

_____

Phone/Fax:_____

To Release Information to:

Rocky Creek Family Medicine (RCFM)
3281 Rocky Creek Drive, Ste 500
Missouri City, TX 77459
Ph : 281-206-0068 Fax : 281-499-5045

Purpose of Release:

[ ] Patient is moving – New Address _____
[ ] Transfer of Care to New Provider/Practice (Last 5 years, unless otherwise specified) _____
[ ] Personal [ ] Receiving Secondary Care [ ] Insurance Purposes
[ ] Other, Please Specify: _____

Information to be released:

[ ] Last one year of medical records
[ ] Last three years of medical records
[ ] Last five years of medical records
[ ] Immunization Records Only
[ ] Radiology Reports
[ ] Other, Please Specify: _____
[ ] Lab Reports Only
[ ] Payment/Claim Records

Sensitive Information to be released:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

[ ] Yes [ ] No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s)/facility listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

[ ] Yes [ ] No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s)/facility listed above.

This authorization may be revoked at any time except to the extent any person has taken action in reliance upon this authorization. Further details on revocation of this authorization are included in the facility's notice of privacy practices. Revocation must be made in writing to the facility releasing the information. Revocation may be the basis for denial of health benefit or other insurance coverage or benefit. Information released pursuant to this authorization may be subject to re-release by the recipient and may no longer be protected by federal or state law. A copy of this authorization is available upon request.

RCFM will not condition treatment on the signing of this authorization. I may refuse to sign. If I refuse to sign, it may result in improper diagnosis, treatment, denial of coverage, denial of claim benefits, denial of other insurance or other adverse consequences.

This authorization expires **12 months** from the date of my signature below. During the 12-month period, RCFM may make subsequent disclosures to the recipient named above.

I, the undersigned, hereby authorize the release of the protected health information described above subject to the restrictions described above:

Patient/Guardian Signature:_____ **Date**: _____

Print Guardian Name, if applicable: _____ **Relationship**: _____

DEADLINE FOR RELEASE OF RECORDS: THE REQUESTED COPIES OF MEDICAL AND/OR BILLING RECORDS OR A SUMMARY OR NARRATIVE OF THE RECORDS SHALL BE FURNISHED BY THE PHYSICIAN WITHIN 15 BUSINESS DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST AND REASONABLE FEES FOR FURNISHING THE INFORMATION.