PEOPLE'S COMMUNITY CLINIC

Authorization to Release Protected Health Information

Attention: This is a legal document. Please read it carefully. By signing, you agree that you understand and accept its terms. *If any section is incomplete, this form may be invalid.*

Patient's Name *(First, Middle, Last):*	Other names used:	Birth Date *(Month DD, YYYY):*	Phone number: ( ) -

Release Information From	*Release Information To*
○ *People's Community Clinic, 2909 N IH-35, Austin, TX 78722 (512) 478-4939 ext. 3004* ○ *Other (Specify facility/individual & address below, including phone/fax if known).* _____ _____ _____ _____	○ *People's Community Clinic, 2909 N IH-35, Austin, TX 78722 (512) 478-4939 ext. 3004 Fax (512) 708-1835* ○ *Other (Specify facility/individual & address below, including phone/fax if known).* _____ _____ _____ _____

Purpose of Release

○ *Continued Care*	○ *Attorney/Legal*
○ *Personal Use*	○ *Insurance*
○ *Other*	

Information to be Released

○ *Clinic Notes*	○ *History/Physical*
○ *Laboratory Reports*	○ *Radiology/EKG Reports*
○ *Immunizations Records*	○ *Problem List*
○ *Prenatal Care*	○ *HIV related information*
○ *Other*	○ *Mental Health, Drug/Alcohol related info*

By signing below, I release People's Community Clinic, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the information identified for release. Any use of this information other than for the purpose(s) stated is expressly prohibited without my written consent. I understand that I may revoke this Authorization at any time, except for actions already taken in good faith. Otherwise, it will expire ninety (90) days from the date of my signature.

Who should sign this form:

- ***If the patient is 18 years of age or older,*** *the patient must sign.*
- ***If the patient is 18 years of age or older but not capable of signing****, a Legal Guardian or Health Care Agent (as designated by a Health Care Power of Attorney) may sign. Please indicate your relationship:*
- _____.
- ***If the patient is 17 years of age or younger****, the patient's parent or Managing Conservator must sign, unless an exception exists under state or federal law. Please indicate your relationship:*
- _____.

Signature (required)	*Date signed (required)*
Printed Name of Person Signing (If not patient)	

Mailing Address of Patient

City	*State*	*Zip Code*	*Phone*

Witness Signature (required)	*Date signed (required)*