Marchand & Associates
FAMILY MEDICINE

Marchand & Associates Family Medicine
Authorization for Release of Patient Information

Patient Name _____ Date of Birth _____

_____
Address City State Zip

Telephone Number(s) **w = work, h= home c= cell** _____

Request Records: Please provide Name of Doctor/ Organization, Address, Phone and Fax Numbers:

To: Dr. Marchand
4534 Westagate Blvd., Suite 113
Austin, TX 78745
Phone: 512.394.6020

From: _____
_____
_____
_____

Description of Information to be released: (please check all that apply) ____ Entire Record or only...

____Immunization record ____Laboratory Reports ____Radiology/ Imaging Reports
____Consultation ____Progress Notes ____Most recent history and physical
____Other _____

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This above information is to be disclosed:

From: Dr. Marchand
4534 Westagate Blvd., Suite 113
Austin, TX 78745
Phone: 512.394.6020

To:_____
_____
_____
_____

Description or the purpose of the use and/or disclosure:

____Continuing Care ___Second Opinion ___ Social Security/ Disability ___Personal Use
____Consultation/ Referral ___Insurance ___Legal purposes
____Other; Please describe_____

I understand that this authorization is voluntary and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand MAFM has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until_____ (date of event).

I understand I may revoke this authorization at any time by notifying the custodian of Medical Records at MAFM. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Person Authorized to Make Request Date