FAMILY FOCUSED CARE
HEALTH FUSION OF TEXAS
FITNESS FUSION
SPA FUSION

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Authorization for Use and Disclosure of Patient Health Information

Name of Patient _____ Maiden or Previous Name _____ Date of Birth _____

Street Address _____ City, State, Zip Code _____

Phone Number: (Home) _____ (Work) _____ (Other) _____

AUTHORIZE:	**RELEASE RECORDS TO:**
Name of Physician/Healthcare Facility	Name of Physician/Healthcare Facility/or Person
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone # Fax #	Telephone # Fax #

☐ Entire Chart
☐ Evaluation Notes
☐ Medication List – Active or Inactive
☐ Lab Results/Pathology Reports
☐ Radiology – All
☐ PAP & Mammogram
☐ Letters
☐ Other: _____

Reason for Disclosure:

I would like this information released for the following purpose:

☐ Continued care by another provider
☐ Legal
☐ Insurance purposes
☐ Social Security Disability
☐ Personal Use
☐ Other _____

I have read and understood the following:

- Except for psychotherapy notes (these notes are not included in my medical record), Family Focused Care will release all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. If I do not want these to be released, I will place a checkmark here: _____. I do not want the following records released: _____
- If I change my mind, I may write to the facility that I have authorized to release my records. This will not apply to records that have already been released.
- This form expires one year after I sign it or sooner (specify here: _____). This time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing these records.
- Once the records are released, Family Focused Care cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless the treatment is part of a research project that requires this authorization.

***** If leaving our clinic- Reason:**

_____ Dissatisfaction _____ Moving _____ Insurance
_____ Convenience of Hours _____ Convenience of Location

_____ _____ _____

Signature of patient or authorized person (If authorized person is signing, please also print name)

Authorized person's authority to sign (parent, guardian, power of attorney, etc.)

Date

***photo ID required to pick up records/films**

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____