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Temple, Texas 76502
www.balanceivtemple.com

254-228-0588 (O)
254-831-8090 (F)
admin@balanceivtemple.com

AUTHORIZATION TO ACCESS OR RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone: _____ Email: _____ SSN: _____

____I request that Balance Integrative and Infusion/Kelli Dudley, FNP-C release my records to the following person or facility:

____I request that the facility below release my records to Balance Integrative and Infusion/Kelli Dudley, FNP-C:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Include this information if applicable: ___Alcohol/drug ___HIV/AIDS ___Genetics ___Mental Health ___Other: _____

___All Medical Records ___Immunization Record ___Lab reports ___X-Ray/Imaging reports ___Summary information (clinic notes, history & physical, operative reports, pathology reports, consults)

___Limit information to records regarding specific illness/injury/mental health (condition and/or approximate dates): _____

PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE(S): ___Continued care ___Insurance ___Personal Use ___Attorney/Legal

I have read and understand the following terms and conditions of this request:

- I understand authorizing the use or disclosure of the information listed above is voluntary and I am not required to sign this authorization to obtain treatment at Balance Integrative and Infusion.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to re-disclosure by the recipient.
- I may revoke this authorization in writing at any time except to the extent Balance Integrative and Infusion has already relied on this authorization.
- My record may contain information that only a physician can interpret. I will contact my physician if I have a question about my diagnosis or treatment. I will not hold Balance Integrative and Infusion liable for any misinterpretation of information if I fail to contact my physician for clarification.

This authorization will expire in 180 days or at the date specified here: _____ (initial here) _____

_____

Signature of Patient or Legal Representative Relationship to Patient Date