



**R. Marcy Henson, DNP APRN FNP-C, Shay Hudson, MS APRN FNP-C**  
**April Morris, DNP APRN AGPCNP-BC, Alie Dodson, MSN APRN FNP-C**  
 301 N. Preston Rd., Ste B, Prosper, TX 75078 PHONE 972-347-1320 FAX 972-347-1322  
 www.familyfocusedcare.com

**Authorization for Use and Disclosure of Patient Health Information**

IF MORE THAN 20 PAGES, PLEASE EMAIL OR MAIL  
[medicalrecords@familyfocusedcare.INFO](mailto:medicalrecords@familyfocusedcare.INFO) Secured medical records email

Name of Patient \_\_\_\_\_ Maiden or Previous Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Street Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_  
 Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

<b>AUTHORIZE:</b>		<b>RELEASE RECORDS TO:</b>	
Name of Physician/Healthcare Facility _____		Name of Physician/Healthcare Facility/or <u>Person</u> _____	
Street Address _____		Street Address _____	
City, State, Zip Code _____		City, State, Zip Code _____	
Telephone # _____	Fax # _____	Telephone # _____	Fax # _____

<input type="checkbox"/> Entire Chart	<input type="checkbox"/> Lab Results/Pathology Reports	<input type="checkbox"/> Letters
<input type="checkbox"/> Evaluation Notes	<input type="checkbox"/> Radiology – All	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Medication List – Active or Inactive	<input type="checkbox"/> PAP & Mammogram	

Reason for Disclosure:	<b>I would like this information released for the following purpose:</b>		
	<input type="checkbox"/> Continued care by another provider	<input type="checkbox"/> Insurance purposes	<input type="checkbox"/> Personal Use
	<input type="checkbox"/> Legal	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> 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

_____ <b>Signature of patient or authorized person</b> (If authorized person is signing, please also print name)	_____ <b>Authorized person's authority to sign</b> <b>Date</b> (parent, guardian, power of attorney, etc.)
<b>*photo ID required to pick up records/films</b>	
<b>REASON PATIENT IS UNABLE TO SIGN:</b> <input type="checkbox"/> Minor <input type="checkbox"/> Deceased <input type="checkbox"/> Other: _____	