Greenhill Family Physicians
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www.gfpcare.com

Authorization for Use and Disclosure of Protected Health Information

Patient Name: ____

SSN: ______________________ Date of Birth: __________________

I authorize the disclosure/release the following information (check all applicable)

- ❑ All records
- ❑ Laboratory/pathology records
- ❑ Xray/radiology records
- ❑ Pharmacy/prescription records
- ❑ Other (describe specifically) ______________________________

I also understand and agree that,

1. photocopy or fax of this form is also valid,
2. Greenhill Clinic, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extend indicated and authorized herein
3. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule

FROM:

Doctor/facility: ____

Address: ____

Phone no: _________________ Fax no: ________________________

TO:

Doctor/facility: ____

Address: ____

Phone no: _________________ Fax no: ________________________

______________________________ ______________________________

Signature of patient or Parent of Minor Date

____

Printed Name of Patient Relationship to patient

Texas Medical board rule 165,1 defines a reasonable fee to charge of no more than $25 for the first 20 pages and /50 cents per page for every copy thereafter. For X-rays $8.00 per film. In addition a reasonable fee may include actual costs for mailing shipping or delivery. The physician shall be entitled to payment of a reasonable fee prior to release of the information unless a licensed Texas Healthcare Provider or Physicians request the information. If requested for the purpose of emergency or acute medical care, the physician shall notify the requesting party writing of the need for payment and may withhold the information until payment of a reasonable fee is received. MR1 (rev 1013)