Texas Integrative Medicine
3006 Bee Cave Rd, Suite A300, Austin, TX 78746
Phone: (512) 800-5309 Fax: (512) 367-5975

Authorization to Release Confidential Health Information

I Hereby Authorize:

- ☐ Texas Integrative Medicine
- ☐ Other: _____ Phone/ Fax:_____

To Release:

- ☐ Complete Chart Record *(does not include billing information or radiographic images)*
- ☐ Chart Notes ☐ All ☐ Specify: _____
- ☐ Labs / Reports ☐ All ☐ Specify: _____
- ☐ Billing Records ☐ All ☐ Specify: _____
- ☐ X-rays / Radiographic images (Specifiy): _____
- ☐ Other: _____

From the Health Records of:

Patient Name: _____ Date of Birth: _____
Daytime Phone: _____ ext:____
Are you authorizing the release of your own records? ☐ Yes ☐ No
If not, what is your relationship to the patient? _____

To Be Released to:

- ☐ Self (please provide current address) ** fee may apply**
- ☐ Texas Integrative Medicine __Wally Taylor MD __Megan Miller NP __Becky Andrews ND, LAc
  3006 Bee Cave Rd, Suite A300 __Kylie Bentley RD
  Austin, TX 78746

- ☐ Facility / Doctor's Name:_____
  Address:_____
  City:_____ State: _____ Zip: _____
  Phone: _____ Fax: _____

For the Purpose of:

- ☐ Adjunctive / Concurrent Care
- ☐ Continuation of Care
- ☐ Transfer of Care
- ☐
- ☐ Legal
- ☐ Insurance
- ☐ Patient Request
- ☐ Other_____

I understand that in order to revoke this authorization, I must do so in writing. I understand that my health care information is protected by state and federal regulations. I understand that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected. I understand that I do not have to sign this form to receive care, and that I am entitled to a copy of this form at the time of signing. I may call the clinic to inquire about revoking authorization. I understand that if I request records for personal use, to hand carry to another provider, or for parties not involved in my health care, there may be a charge. There is no charge to release records to another healthcare provider. This authorization expires in _____ days (90 days if not otherwise specified). Minors signature required for certain conditions.

_____ _____ _____
Patient Signature Date Relationship to Patient