Taylor Family Practice
Dr. Jill A. Taylor

Phone#: 281-359-4220
Fax#: 281-359-4208

Authorization for Release of Healthcare Information

Patient Name: _________________________________ **DOB: ___________________**

I hereby authorize the transfer/receipts of the following healthcare information:

To: **Taylor Family Practice**
1806 Humble Place Dr.
Humble, TX 77338

From previous Doctor:
____
____
____

Phone#: _________________________________
Fax#: _________________________________

****MOST RECENT ONLY**** **___ Pap** **____ MAMMOGRAM** **____ LABS**

Purpose of Disclosure: ________ Continuing Patient Care **______ Other**

I understand the specific information to be released may include, but is not limited to the history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand the consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to Taylor Family Practice Medical Record Department. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this to this authorization may be subject to re-disclosure by the recipient and is no longer protected. Taylor Family Practice, its employees and partners and providers are released from legal responsibility for the release of the above information to the extent indicated and authorized herein.

_____________________________ (Signature of Patient) ___________ (Date) _____________________________ (Signature of Patient's Representative) ________ (Date)

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