Uncommon Healthcare
Connecting · Caring

1000 W. State Hwy 6, Suite 100
Waco, Texas 76712
Ph: 254-339-1360 Fax: 254-300-9110

AUTHORIZATION TO ACCESS OR RELEASE MEDICAL INFORMATION

Patient Name Date of Birth

Address City, State Zip

Phone number Social Security #

____ I request that **Uncommon Healthcare/Dr. Felicia K. Macik** release my records to the following person or facility:

____ I request that the facility below release my records to **Uncommon Healthcare/Dr. Felicia K. Macik**

Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Include this information (if applicable): ___ *Alcohol/Drug* ___ *HIV/AIDS* ___ *Genetics* ___ *Mental Health*

____ *Limit to records regarding specific illness/injury/mental health (condition and/or approximate dates):*

_____

____ *All Medical Records* ____ *Immunization Record* ____ *Lab Reports* ____ *X-ray/Imaging Reports*

____ *Summary Information (Clinic notes, history & physical, operative reports, pathology reports, consults.)*

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 Uncommon Healthcare.
- 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 Uncommon Healthcare 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 Uncommon Healthcare 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