DHCHD
Dallam Hartley Counties Hospital District

DALHART FAMILY MEDICINE CLINIC
206 E. 16th Street, Dalhart TX 79022
P (806) 244-5668 W: dhchd.org

HIGH COUNTRY RURAL HEALTH CLINIC
320 E Texas Blvd., Dalhart, TX 79022
P (806) 244-8324 W: dhchd.org

AUTHORIZATION FOR RELEASE INFORMATION

(THIS MUST BE FILLED OUT COMPLETELY)

Patient Name: _____DOB: _____

SS#: _____Address: _____

I authorize DALHART FAMILY MEDICINE CLINIC to disclose my individual health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes) chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal and state privacy regulations, I understand that mt Health care and the payment of my Health Care will not be affected if I do not sign this from.

Information To Be Released To:

DALHART FAMILY MEDICINE CLINIC
PO BOX 1208/ 206 EAST 16TH ST
DALHART, TEXAS 79022
Fax:
Phone: 806-244-5668

FROM:

_____
_____
_____
_____

(IF MORE THAN 30 PAGES PLEASE DO NOT FAX)

Information to be released (check all that apply)

__History/Physical exam notes
Dates: _____
__Laboratory Reports
Dates: _____
__X-Ray Reports
Dates: _____

__Other Diagnostic Reports
Dates: _____

__Other (please specify)
_____
_____

Reason or Purpose for Release (check the appropriate category)

__Continue Patient Care
__Attorney Legal
__Insurance Claim Application
__Personal Use
__Other_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patients is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the day of my signature unless otherwise specified.

X_____ _____
Patient Signature (Guardian if minor) Date

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Information To Be Released To:

_____
_____
_____
_____
_____

FROM:

Dalhart Family Medicine Clinic
PO BOX 1208/206 East 16th
Dalhart, TX 79022
Fax:
Phone: 806-244-5668

(IF MORE THAN 30 PAGES PLEASE DO NOT FAX)

Information to be released (check all that apply)

__History/Physical exam notes
Dates: _____
__Laboratory Reports
Dates: _____
__X-Ray Reports
Dates: _____

__Other Diagnostic Reports
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