**•Authorizing information for the following patient:**

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Other Name(s) Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**•Authorizing the Health care provider, Dr or Facility to disclose this information:**

Dr’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**•Authorizing the following facility and Dr to receive and use this information:**

BCS Abundant Life Family Practice, P.A.

Russell Bacak, M.D. and Sarah Ezell, M.S., PA-C

2803 Earl Rudder Fwy- South, Suite 201, College Station, TX 77845

Phone: 979-695-3570 Fax: 979-695-3573

**•Specific information to be disclosed:**

□ Medical Record from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Entire Medical Record**, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

\*\*Fax accepted for all records fewer than 10 pages.\*\*

\*\*Please mail records longer than 10 pages to the above address\*\*

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment. I understand that I have the right to revoke this authorization at any time and may do so in writing. Refusal to sign this authorization will not determine treatment, payment, enrollment, or eligibility of benefits. This release will remain effective for one year from the date listed below unless authorization is revoked in writing.

Patient/Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Legal Representative, relationship to Patient:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Minor (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_