GOLIAD
HEALTH & WELLNESS

MEDICAL RECORDS RELEASE - AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Phone:_____

Date of Birth: _____ Social Security #: _____ (optional)

I authorize Goliad Health & Wellness located at 206 S. Washington St.; Goliad, TX 77963 to disclose the individual's protected health information (Medical Records) to the following Organization/Provider or directly to myself as follows:

Organization/Person: _____(if releasing directly to self, please indicate "self" on this line)

Address: _____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Please release the following:

_____ Medical Record from (insert date) _____ to (insert date) _____

_____ Entire Record, including patient histories, office notes, test results, radiology studies, referrals, consults, billing records, insurance records, and records received from other health care providers.

_____ Other (please specify): _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ Yes, I consent to release this information. _____ No, I do not consent to the release of this information.
I understand that the information release is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expired upon completion of this request.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization I need not to sign this from in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold *GOLIAD HEALTH & WELLNESS liable* for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Relationship to Patient (if Legal Representative) **Witness**

Before August 28, 2026, return form to 206 S. Washington St. Goliad, TX 77963, Ph. 361-645-7777
After August 28, 2026, return form to P. O. Box 6844; Corpus Christi, TX 78466, Ph. 361-882-3133