Stefanie McCain, M.D.
Stacy D. Hammond, FNP-C
19 Hospital Drive
Abilene, TX 79606
Office: 325-690-0620 Fax: 325-690-0622

Authorization to Release Medical Information

I understand that I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the office. Unless revoked, this authorization will expire in 180 days from the date signed.

I also understand that once the health information I have authorized to be disclosed reaches the noted recipient, the person or organization may re-disclose it. At this time it may no longer be protected under privacy laws. Records received by this office will not be re-disclosed without written authorization by the patient.

Please release my healthcare information to/from:

Stefanie McCain, M.D.
Stacy D. Hammond, FNP-C
19 Hospital Dr.
Abilene, TX 79606
Office: 325-690-0620
Fax: 325-690-0622

Please release my healthcare to/from:

_____
_____
_____
_____
_____

Information to be released:

Lab Result__	Pap Smear__	Radiology Services__
Op Reports__	Entire Records__	History and Physical only__
Discharge summary__	HIV test__	Other_____

Purpose of disclosure:

Personal use: ____ Transfer of Care: ____ other: _____

Patient Authorization:

I understand that the information in my health records may include information relating to sexually transmitted diseases, AIDS, and HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Treatment and payment may not be conditioned upon authorization. There may be a charge for copying records. **Initial**_____

Signature: _____ **Date**_____
Signature of parent/guardian if needed: _____
Printed Name_____ **SSN:**_____
DOB:_____ **Maiden or other Name:**_____