

Stefanie McCain, M.D.
Stacy D. Hammond, FNP-C
19 Hospital Drive
Abilene, TX 79606

Office: 325-690-0620

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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:

Please release my healthcare 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

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: _____