Jose B. Benigno Medical Clinic, P.A.
115 W 42nd St., Odessa, TX 79764
Telephone: (432) 367-4817 • Fax: (432) 367-4813

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

HIPAA-Compliant Medical Records Request

1. PATIENT INFORMATION

Patient Full Name (Last, First, Middle)	Former / Maiden Name(s)	Date of Birth (MM/DD/YYYY)

Street Address	City, State, ZIP Code	Telephone Number

2. RECIPIENT INFORMATION (WHO MAY RECEIVE THE RECORDS)

I authorize **Jose B. Benigno Medical Clinic, P.A.** to release my protected health information to:

☐ **West Texas Medical Care** (Continuing Care Transfer) — Address / Phone / Fax: _____

☐ **Patient / Self** (Send directly to my address or email listed above)

☐ **Other Provider / Recipient:** Name: _____ Phone/Fax: _____

Recipient Address (if Other): _____

3. INFORMATION TO BE RELEASED & PURPOSE

Records Requested: ☐ Complete Medical Record (Recommended for Care Transfer) ☐ Pertinent Clinical Summary / Recent Notes (Last 2 Years)

☐ Specific Records Only (Check all that apply): ☐ Lab/Pathology ☐ Radiology/Imaging ☐ Immunization Record ☐ Medication List ☐ Other: _____

Date Range: From _____ To _____ **Purpose of Disclosure:** ☐ Continuity of Care / Physician Retirement ☐ Personal Use ☐ Other: _____

Sensitive Information Authorization (Initial to Include): Unless initialed below, records relating to the following conditions will NOT be released:

_____ Mental Health / Behavioral Health _____ HIV / AIDS / Communicable Diseases _____ Substance / Alcohol Use Disorder
_____ Genetic Testing

4. PATIENT RIGHTS & LEGAL ACKNOWLEDGMENTS (HIPAA & TEXAS MEDICAL PRIVACY ACT)

Right to Revoke: I understand that I may revoke this authorization at any time by submitting a written request to Jose B. Benigno Medical Clinic, P.A., except to the extent that action has already been taken in reliance upon it.

Voluntary Authorization: I understand that authorizing the disclosure of this health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon signing this authorization.

Redisclosure Notice: I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy regulations.

Expiration: Unless revoked earlier, this authorization expires 180 days from the date signed below, or upon completion of this transfer request, whichever occurs first.

5. SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

Signature of Patient or Legal Representative	Printed Name	Date Signed

If signed by a Legal Representative, state relationship to patient and authority to act (e.g., Parent, Legal Guardian, Medical Power of Attorney — attach documentation if not on file)

Return Completed Form To: Jose B. Benigno Medical Clinic, P.A. • 115 W 42nd St., Odessa, TX 79764 • Fax: (432) 367-4813