Elisabeth Potter, MD, PLLC

Release of Information Form

Patient Name _____ Birth Date _____/_____/_____

The patient listed above hereby authorizes the following entity:

Name _____ ❑ Self ❑ Physician ❑ Other

Address _____ Zip Code _____

Phone (_____) _____-_____ Fax (_____) _____-_____

❑ **to request information from** ❑ **to send information to** ❑ **to discuss information only with**

Elisabeth Potter, MD, PLLC
Phone: (512) 867-6211 6818 Austin Center Blvd. Ste. 204 Fax: (512) 888-9567
Austin, TX 78731

REGARDING: ❑ Demographics & Medical Records ❑ Billing & Financial Records ❑ Photos

METHOD: ❑ Print ❑ Mail ❑ Fax ❑ Transfer to USB provided by patient (photos only)

TIMEFRAME: ❑ Entirety of Care ❑ Date Range _____ to _____

PURPOSE: ❑ Medical ❑ Insurance ❑ Disability & Leave ❑ Legal ❑ Personal ❑ Other

I understand that:

- By signing, I am authorizing the release of private information which may include information protected under HIPAA regarding communicable diseases or mental illness
- If the receiving party is not subject to privacy laws, the information being released may not be protected and could be subject to an unauthorized disclosure, for which this provider and all of those associated with the practice would not be held liable
- I have the right to review any disclosed information according to the Privacy Practices
- The duration of this authorization will be for one year unless revoked in writing
- If revoked, it will not apply to any information that has already been released
- If revoked, it will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy
- There may be a fee associated with requesting medical information
- Authorizing the disclosure of this information is voluntary; I may refuse this authorization, but it could hinder my healthcare provider's ability to properly assist in my treatment

Patient Signature _____ Date _____