TM

Authorization to Disclose Protected Health Information

I hereby authorize:

Doctor / Hospital name: ______________________________

Telephone No.: ____________________ Fax No.: ____________________

To release to:

Name: ______________________________

Address: ____________________ City, State, Zip Code: ____________________

Telephone No.: ____________________ Fax No.: ____________________

Release medical records on:

Patient Name: ____________________ Telephone No.: ____________________

Date of Birth: ____________________ Social Security No: ____________________

Information to be released:

- ☐ All Medical Records
- ☐ Demographics, Insurance Card
- ☐ Last 2 office notes
- ☐ Dates of Treatment: _________ to _________
- ☐ All diagnostic tests (X-Ray, CT – Scan & MRI)
- ☐ Other: ____________________

Information to be released for the following purpose:

- ☐ Medical care
- ☐ Patient request
- ☐ Other ____________________
- ☐ Social Security Disability
- ☐ Attorney

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the provider(s) office. This authorization will automatically expire 120 days from the date of my signature unless revoked prior to the time or unless otherwise specified as follows

Re-disclosure:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative:

I understand that TX-An Anesthesia & Pain Mgmt, LLP may not condition my treatment whether I sign this authorization form. I authorize TX-An Anesthesia & Pain Mgmt, LLP to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

Signature of Patient/ Legal Representative: ______________________________ Date: ____________

Authority to sign if not Patient (documentation required): ______________________________ Date: ____________

Identity of Requestor verified by: ____Photo ID ___ Matching Signature

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