

Authorization to Disclose Health Information



Patient Name (Print): _____ Date of Birth: _____

Release Protected Health Information To:

Send Records To:

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Protected Health Information From:

Personal MD Family Healthcare, P.A.
2770 Virginia Parkway, Suite 301, McKinney, Texas 75071
Phone: 214-726-0755 Fax: 214-585-0449

What Information Can Be Disclosed:

All Health Information EKG/Cardiology Reports Past/Present Medication
Immunization History Radiology reports Operation Reports
Laboratory Results Pathology Results Other:
Records from the following dates: _____ to _____

Your initials are required to release the following information:
Mental Health Records (excluding psychotherapy notes) Drug, Alcohol, or Substance Abuse Records
Genetic Information (including Genetic Test Results) HIV/AIDS Test Results/Treatment

Reason For Disclosure:

Changing Physicians Billing or Claims Insurance Evaluation
Legal Purpose Employment School
Personal Use Other:

Signature Authorization:

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual: the individual reaching the age of majority; or permission is withdrawn; or the following specific date:

Right To Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named "Release Protected Health Information To." I understand that prior actions taken in release of this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that is permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154c and/or 45 c.F.R. 164.502a1.

SIGNATURE _____ DATE: _____
Signature of Individual or Individual's Legally Authorized Representative

If you are a representative, specify your relation to the individual: Parent Guardian Other

Signature of Minor: _____ Needed for the release of information related to reproductive care, sexually transmitted diseases, drug, alcohol, or substance abuse, and mental health treatment (See Tex. Fam. Code 32.003)